

Office of Legislative Oversight  
**MEMORANDUM REPORT**

September 21, 2010

TO: County Council

FROM: Jennifer Renkema, Research Associate  
Office of Legislative Oversight

SUBJECT: **OLO Memorandum Report 2011-1:  
An Overview of Publicly-Funded Family Planning Programs**

The Council requested this Office of Legislative Oversight report to better understand “Medicaid waiver programs” that expand eligibility for Medicaid family planning services, and how such programs have been implemented in other states. The purpose of the report is to help the Council decide whether to seek changes to Maryland’s waiver program during the 2011 General Assembly session.

**Overview of Findings.** Twenty-seven states, including Maryland, have expanded access to Medicaid family planning services using waiver programs approved by the federal Centers for Medicare and Medicaid Services. State waiver programs can be grouped into three broad categories:

- Expansions that provide family planning services based on income;
- Expansions that provide continued family planning services to women who are losing any other Medicaid coverage; and
- Expansions that provide extended family planning services to women who lose coverage after a Medicaid-funded birth.

Besides expanding coverage eligibility, states have implemented various practices to further improve access to services. These include outreach to the target population and potential new providers, simplified enrollment procedures, special confidentiality rules, and eligibility for teens and men.

Several studies show that waiver programs improve access to services by increasing the number of women served, the percent of women in need who access services, and the number of family planning service providers who participate in public programs. One study indicates that income-based waiver programs are more effective than other types of waiver programs at expanding access. Studies also demonstrate that waiver programs produce Medicaid cost savings for states and the Federal Government. Although the impact on unintended pregnancy rates is inconclusive, some evaluations indicate that programs reduce birthrates among the target population and program participants.

**Origin of Assignment.** Councilmember Trachtenberg recommended this OLO project, based on the report of the Reproductive Health, Education, and Advocacy Workgroup, and subsequent issues identified by the Council's Health and Human Services Committee.

The Workgroup's report, issued earlier this year, concluded that teens and low-income women in Montgomery County need improved access to family planning services. To help address this gap, the Workgroup recommended the County advocate for changes at the state level to expand Medicaid coverage for family planning services through a federal Medicaid waiver. In April, 2010, the HHS Committee agreed this was an issue worth researching further.

**Maryland's Current Waiver.** Maryland currently has a limited family planning waiver program that provides family planning services to postpartum women with incomes up to 200% of the FPL who would otherwise lose Medicaid coverage after giving birth. Women may be enrolled in the program for up to five years. The State is applying for an extension to the existing waiver, which is scheduled to expire in June 2011.

**Proposed Changes to Maryland Family Planning Services.** In 2009 and 2010, the General Assembly introduced legislation to expand family planning coverage under Maryland's Medicaid program to women with incomes up to 250% of the FPL (up from 116%). The legislation was withdrawn primarily due to concerns about funding \$3 million in start-up costs for the first year of the program. If implemented, however, an income-based Medicaid family planning program would likely generate substantial cost savings in future years as a result of fewer unintended births.

Following Federal health care reform legislation passed earlier this year, Maryland would no longer need a waiver to implement the proposed income-based family planning program.

**Methodology.** OLO staff member Jennifer Renkema authored this report with assistance from Sue Richards. OLO gathered general information through Internet research; and compiled specific information about family planning services in Maryland and Montgomery County through interviews with staff in the County's Public Health Services in the Department of Health and Human Services and the State's Department of Health and Mental Hygiene.

**Acknowledgments.** OLO appreciates the assistance of Montgomery County Department of Health and Human Services staff Pat Brennan, Dianne Fisher, Doreen Kelly, and Ranita Williams and Maryland Department of Health and Mental Hygiene staff Bonnie Birkle, Alice Middleton, Tricia Roddy, and Nadine Smith. OLO would also like to thank Jeremy Crandall, Legislative Aide to Delegate Health Mizeur. In addition, OLO staff member Teri Busch provided valuable technical assistance.

**Organization of the Report.** This memorandum report is organized into five chapters as follows:

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1	<b>Publicly Funded Family Planning Services:</b> This chapter defines publicly funded family planning services, describes the need for services, and explains Medicaid and Title X funding and coverage.	4
2	<b>Medicaid Waivers for Family Planning Program Expansions:</b> This chapter describes how states use waivers to expand eligibility for Medicaid family planning services, summarizes the research evaluation literature, and offers examples of specific implementation practices.	15
3	<b>Publicly-Funded Family Planning Services in Maryland and Montgomery County:</b> This chapter describes current publicly-funded family planning services available in Maryland and Montgomery County.	23
4	<b>Legislation Affecting Publicly-Funded Family Planning Services:</b> This chapter reviews recent legislative efforts affecting publicly-funded family planning services and identifies changes to Maryland's program that could improve access.	32
5	<b>Summary of Findings:</b> This chapter summarizes OLO's findings about Medicaid waiver programs and the potential impact of implementing a more expansive waiver in Maryland.	37
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## CHAPTER 1. Publicly-Funded Family Planning Services

Ready access to family planning services is a key component of women's health services, particularly for teens and low-income women who are at a higher risk for unintended pregnancies. Publicly-funded family planning services are accessible through a provider network of state Medicaid programs and clinics that receive Title X grants. Medicaid programs provide free family planning services to teens and women who qualify for full Medicaid coverage whereas Title X clinics provide services on a sliding scale for clients with incomes up to 250% of the federal poverty level (FPL).

This chapter provides information about publicly-funded family planning services as background for a discussion of states' Medicaid waiver program practices (in Chapter 2) and Maryland and Montgomery County's family planning services programs (in Chapter 3). This chapter is organized as follows:

**Section A** provides a definition of family planning services;

**Section B** presents an estimate of the need for family planning services;

**Section C** summarizes research about unintended pregnancy rates, the disproportionate occurrence of unintended pregnancy among certain populations, and the effectiveness of publicly-funded family planning services; and

**Section D**, provides an overview of the national service delivery framework and funding sources for publicly-funded family planning services programs, particularly Medicaid and Title X.

### A. The Definition of Family Planning Services

Health researchers define family planning services as an array of education and contraceptives designed to help women and couples plan the timing of conception and family size. The services aim to reduce the number of unintended pregnancies and the risks associated with them.

Most basic family planning services include education and reversible contraceptives. Other services typically include reproductive health screening (e.g., breast and pelvic exams and Pap smears), pregnancy testing, screening for sexually transmitted infections (STIs) and HIV, and treatment for STIs or other diagnoses. Some programs include sterilization services. Family planning programs serve mostly women, and programs occasionally provide outreach to the community.<sup>1</sup>

### B. The Need for Publicly-Funded Family Planning Services

The Guttmacher Institute periodically estimates the number of women in need of "publicly-supported contraceptive services and supplies." Guttmacher assumes any woman needs contraceptive services and supplies if she is: sexually active, able to become pregnant, and at some point in the year is neither pregnant nor trying to become pregnant.<sup>2</sup> Guttmacher assumes a woman is in need of *publicly supported* contraceptive services and supplies if:

- She is under 20 years old (regardless of her family or household income) or
- She is 20 or older and her family income is up to 250% of the federal poverty level (FPL).<sup>3</sup>

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<sup>1</sup> Gold, et. al., (2009). *Next Steps for America's Family Planning Program*

<sup>2</sup> Guttmacher. (2009). *Contraceptive Needs and Services*, 2006

<sup>3</sup> Ibid.

The Guttmacher Institute assumes that all women younger than 20 who need contraceptive services need publicly-funded care, “either because their personal incomes are under 250% of the FPL or because of their heightened need—for reasons of confidentiality—to obtain care without depending on their family’s resources or private insurance.”<sup>4</sup>

The Guttmacher Institute found that, in 2006, nine million clients received publicly-funded family planning services. About 7.5 million women received these services at a publicly-funded clinic through Medicaid or Title X, and the remaining women received services from private physicians through Medicaid. In all, Guttmacher estimates that publicly-funded programs served about 54% of women who were “in need” of publicly-funded contraceptive services; 40% received services from a clinic and 14% accessed services through private providers under Medicaid.<sup>5</sup>

Guttmacher data show that the need for publicly-funded contraceptive services increased both nationally and in Maryland between 2002 and 2006. In contrast, the need in Montgomery County actually decreased slightly over the same time period (Table 1-1)<sup>6,7</sup> Specifically between 2002 and 2006:

- Nationally, women who needed publicly-funded family planning services increased 4.2 percent, from 16.8 million to 17.5 million.
- In Maryland, the need increased 5.3% from 245,580 to 258,560.
- In Montgomery County, the need declined 1.6% from 31,060 to 30,560.

**Table 1-1: Women in Need of Publicly Supported Family Planning Services, 2002 and 2006**

Jurisdiction	2002	2006	% Change
National	16,776,730	17,485,330	4.2%
Maryland	245,580	258,560	5.3%
Montgomery County	31,060	30,560	-1.6%

Source: Guttmacher Institute<sup>6</sup>

### C. A Summary of Research Results

This section summarizes five research studies about the rates and effects of unintended pregnancy and the effectiveness of publicly-funded family planning services to reduce these rates. In brief, this research shows that:

- Unintended pregnancies account for a large share of pregnancies in the United States and these pregnancies pose risks for both the mothers’ health and the children’s health and development;
- Teens and low-income women have disproportionately higher rates of unintended pregnancies; and
- Teens and low-income women who have access to publicly-funded family planning services use more effective contraceptive methods and have reduced rates of unintended pregnancies.

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<sup>4</sup> Ibid., p. 6

<sup>5</sup> Gold, et. al., (2009). *Next Steps for America’s Family Planning Program*

<sup>6</sup> Guttmacher. (2004). *Contraceptive Needs and Services, 2001-2002*; Guttmacher. (2009). *Contraceptive Needs and Services, 2006*

<sup>7</sup> A 2008 update report from Guttmacher shows very slight (less than 1%) decreases in need from 2006 to 2008 nationally and in Maryland. Data for Montgomery County were not readily available. (Frost, et. al., (2010) *Contraceptive Needs and Services: 2008 Update*)

**Unintended Pregnancy Rates and Effects.** In 2001 nearly half (49%) of pregnancies in the United States were unintended. (Unintended pregnancies include both those that are mistimed and those that are unwanted.) Of these pregnancies, 44% resulted in births, 42% in abortions, and 14% in miscarriages.<sup>8</sup> Studies show that unintended pregnancy negatively affects preconception care, prenatal care, maternal and infant health, and child development. Specifically:

- A woman who does not plan her pregnancy may not receive preconception care and may delay prenatal care, which can increase health risks for mothers and babies;<sup>9</sup>
- Women who have unintended pregnancies experience higher rates of postpartum depression;<sup>10</sup> have higher morbidity rates; and are more likely to engage in risky behaviors (e.g., smoking, alcohol consumption, or drug use) during pregnancy;<sup>11</sup>
- Babies born as a result of unintended pregnancies have higher rates of preterm delivery and low birthweight;<sup>12</sup>
- Children born from unintended pregnancies experience lower levels of educational attainment, more mental and physical health problems, and a more stressed mother-child relationship.<sup>13</sup>

In addition, unintended pregnancy among teenage women can negatively affect their education and ability to participate in the workforce.<sup>14</sup>

**Unintended Pregnancy Occurs Disproportionately Among Low-Income, Minority, and Young Women.** In 2001, the rate of unintended pregnancy among all women was 51 per 1,000 women. A 2006 study by Finer and Henshaw reported that the rate of unintended pregnancy, abortion, and unintended birth was significantly higher among young women, low-income women, and African American and Hispanic women, as shown in Table 1-2. Specifically:

- The rate of unintended pregnancy among women age 18-19 (108 per 1,000) and women age 20-24 (104 per 1,000) was more than double that of all women (51 per 1,000).
- The rate of unintended pregnancy among women with the lowest incomes (under 100% of the FPL)<sup>15</sup> was 112 per 1,000 women. The unintended pregnancy rate for this cohort was about 1.5 times the rate for women with incomes between 100%-199% of the FPL (81 per 1,000), and about four times the rate for women with incomes at or above 200% of FPL (29 per 1,000).
- The rate of unintended pregnancy among African American women (98 per 1,000) was nearly triple the rate among white women (35 per 1,000). The rate among Hispanic women (78 per 1,000) was about double that of white women.

Finer and Henshaw found that racial disparities persisted even when controlling for income.<sup>16</sup>

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<sup>8</sup> Finer, L.B. & Henshaw, S.K. (2006). *Disparities in Rates of Unintended Pregnancy*

<sup>9</sup> The National Campaign to Prevent Teen and Unplanned Pregnancy. (2008). *Consequences of Unplanned Pregnancy*; U.S. DHHS Centers for Disease Control. (n.d.) *Unintended Pregnancy Prevention*

<sup>10</sup> The National Campaign to Prevent Teen and Unplanned Pregnancy. (2008). *Consequences of Unplanned Pregnancy*

<sup>11</sup> U.S. DHHS Centers for Disease Control. (n.d.) *Unintended Pregnancy Prevention*

<sup>12</sup> The National Campaign to Prevent Teen and Unplanned Pregnancy. (2008). *Consequences of Unplanned Pregnancy*  
<sup>13</sup> Ibid.

<sup>14</sup> Gold, R.B. (2006). *Rekindling Efforts to Prevent Unplanned Pregnancy*

<sup>15</sup> In 2010, the FPL for a family of four is \$22,050. A more complete table, including 200% and 250% FPL is included at Appendix B.

<sup>16</sup> Finer, L.B. & Henshaw, S.K. (2006). *Disparities in Rates of Unintended Pregnancy*

**Table 1-2: Disparities in Unintended Pregnancy, Abortion, and Unintended Birthrates Among Women in the United States, 2001**

	<b>Unintended Pregnancy Rate*</b>	<b>Abortion Rate</b>	<b>Unintended Birthrate</b>
All women	51	21	22
<b>Income Disparity</b>			
Below 100% of FPL	112	42	58
100% - 199% of FPL	81	50	35
Income 200%+ of FPL	29	13	11
<b>Racial/Ethnic Disparity</b>			
White	35	13	17
African American	98	49	35
Hispanic	78	30	40
<b>Age Disparity</b>			
Age 18-19	108	37	53
20-24	104	45	46

\*Rates per 1000 women; abortion rate plus unintended birthrate do not equal the unintended pregnancy rate due to miscarriage

Source: Finer, L.B. & Henshaw, S.K.<sup>16</sup>

Finer and Henshaw also found that differences between rates of intended pregnancy by income level had increased over time. Specifically, between 1994 and 2001, unintended pregnancy rates increased:

- From 87 to 112 per 1,000 among women with incomes below 100% of the FPL; and
- From 65 to 81 per 1,000 among women with incomes between 100% and 199% of the FPL.

Over the same time period, unintended pregnancy rates decreased from 37 to 29 per 1,000 among women with incomes above 200% of the FPL. The same trends occurred for abortions and unintended births.<sup>17</sup>

**Estimates of Averted Pregnancies Due to Publicly-Funded Family Planning Services.** Ready access to family planning services reduces the number of unintended pregnancies, including teen pregnancies. A 2008 study by Frost, Finer, and Tapales provides an estimate of births averted due to publicly-funded family planning programs. The study estimated that services provided in 2004 by publicly-funded family planning clinics (with and without Title-X funding) helped women avoid 1.4 million unintended pregnancies, or 242 pregnancies per 1,000 patients.

In addition, the study estimated that, out of these 1.4 million averted pregnancies: about one million would have been to unmarried women or women with incomes under 200% of the FPL; about 290,000 of the averted pregnancies would have occurred among teens; and slightly less than half (600,000) would have ended in abortions.

Similarly, a study by the Guttmacher Institute estimates that publicly-funded family planning services helped women avert about 1.94 million unintended pregnancies in 2006. Of these averted pregnancies, Guttmacher data indicate:

- About 870,000 would occur among women with incomes below the FPL, and another 520,000 would occur among women with incomes between 100-199% of the FPL.

<sup>17</sup> Ibid.

- Without publicly-supported family planning services, unintended pregnancy rates among teens would be 60% higher; and rates among women with incomes under 100% of the poverty level would double.
- Clients of publicly-funded family planning clinics have 78% fewer unintended pregnancies than similar women who do not have access to family planning services.
- Among women who use contraception and receive services at a publicly-funded family planning center, three-quarters use a highly-effective method.<sup>18</sup>

Citing several other studies, Finer and Henshaw found risk factors that may contribute to income disparities in unintended pregnancy rates. Specifically, they cite studies that indicate low-income women are less likely to use contraception than women with higher incomes and that when they do use a contraceptive, they are more likely to experience method failure. Finer and Henshaw conjecture that these disparities may be because low-income women have less access to family planning services, pointing to the high rate of uninsured low-income women and decreases in funding for Title X family planning services (see page 9 for a more detailed discussion of Title X funding).<sup>19</sup>

#### **D. An Overview of Publicly-Funded Family Planning Services Funding Patterns**

Five different sources of federal and state aid fund the network of providers and clinics that provide critical access to family planning services for low-income women.<sup>20</sup> Medicaid and Title X of the Public Health Services Act are the primary sources of federal funding for family planning services, followed by state appropriations that fund state Medicaid programs or supplement federal Title X funds. Three block grant programs - the Maternal and Child Health Block Grant, Social Services Block Grant, and Temporary Assistance to Needy Families – fund a more limited set of family planning services.<sup>21</sup>

In theory, a family planning services clinic or provider could offer a comprehensive array of services; however, in practice, a specific program's funding source and regulations usually determine the services that are eligible for reimbursement. For example, family planning services paid for with federal or State of Maryland dollars do not cover abortion.<sup>22</sup> Other publicly-funded family planning services may or may not include sterilization or treatment for STIs.<sup>23</sup> Some publicly-funded programs provide services for men.<sup>24</sup> Multiple program factors – funding, administration, definitions of family planning services – can affect access to family planning services. To understand these factors, this section explains the funding history of family planning services, provides data about current funding sources, and offers a more detailed picture of Medicaid and Title X services.

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<sup>18</sup> Gold, et. al., (2009). *Next Steps for America's Family Planning Program*

<sup>19</sup> Finer, L.B. & Henshaw, S.K. (2006). *Disparities in Rates of Unintended Pregnancy*

<sup>20</sup> Gold, et. al., (2009). *Next Steps for America's Family Planning Program*

<sup>21</sup> Sonfield, et. al., (2008). *Public Funding for Family Planning, Sterilization, and Abortion Services, FY 1980-2006*

<sup>22</sup> Federal funds may only be used for abortions in cases of rape, incest, or if the mother's life is in danger. Maryland covers abortions that are "medically necessary" for women with full Medicaid coverage, but abortion is not considered a family planning service. [Guttmacher. (2010). *State Funding of Abortion Under Medicaid*]

<sup>23</sup> Gold, et. al., (2009). *Next Steps for America's Family Planning Program*

<sup>24</sup> Gold, et. al., (2009). *Next Steps for America's Family Planning Program*; Guttmacher. (2010). *State Medicaid Family Planning Eligibility Expansions*



**Historic Funding Levels and Sources.** Since 1980, three funding trends have shaped public funding for family planning services (Table 1-3):

- First, between 1980 and 2006, overall public funding for family planning services increased about 17.6%, from \$1.57 billion to \$1.85 billion, when adjusted for inflation.<sup>25</sup>
- Second, since 1980, Title X funding decreased while Medicaid spending increased, and eventually Medicaid replaced Title X as the primary funding source for family planning services. In 1980, Medicaid provided 20% of public funding for family planning services, compared to 44% from Title X. By 1994, Medicaid contributed 47% and Title X provided 21%. By 2006, Medicaid's share of funding reached 71% of funding and Title X was only 12%.<sup>26</sup>
- Third, much of the recent growth in Medicaid funding between 2001 and 2006 reflects increased Medicaid spending for waiver programs that allow states to expand family planning coverage to more women, usually based on income. (See Chapter 2 for a discussion of family planning waiver programs.)<sup>27</sup>

**Table 1-3: Trends in Public Expenditures for Family Planning Services, 1980 - 2006 (constant 2006 dollars, in millions)**

	1980	1987	1994	2001	2006
Total Expenditures	\$1,570	\$1,067	\$1,133	\$1,550	\$1,847
<b>Percent of Expenditures by Funding Source</b>					
Medicaid	20%	33%	47%	61%	71%
Title X	44%	32%	21%	15%	12%
Other Federal	22%	17%	10%	9%	4%
State Appropriations	15%	16%	23%	15%	13%

Source: Guttmacher Institute<sup>25</sup>

**Current Funding Levels and Sources.** In 2006, public expenditures nationwide for family planning services totaled about \$1.8 billion. Of these funds:

- About 70 percent (\$1.3 billion) represented federal and state Medicaid expenditures;
- About 12 percent ( \$215 million) represented federal and state Title X expenditures; and
- About 13 percent (\$241 million) represented other<sup>28</sup> state-funded family planning services.<sup>29</sup>

<sup>25</sup> Sonfield, et. al., (2008). *Public Funding for Family Planning, Sterilization, and Abortion Services, FY 1980-2006*

<sup>26</sup> Ibid.

<sup>27</sup> Ibid.

<sup>28</sup> For example, Maryland's Title X program receives State appropriations for teen pregnancy prevention that exceed the State's required match for Federal Title X funding. (Bonnie Birkel, DHMH Family Service Administration, Personal Communication.)

<sup>29</sup> Sonfield, et. al., (2008). *Public Funding for Family Planning, Sterilization, and Abortion Services, FY 1980-2006*

**Table 1-4: Public Expenditures for Family Planning Services, 2006**  
(\$ in millions)

Funding Source	Expenditures	% of Total
Medicaid	\$1,304	70.6%
Title X	\$215	11.7%
Other Federal sources*	\$86	4.7%
State appropriations	\$241	13.1%
<b>Total</b>	<b>\$1,847</b>	<b>100%</b>

\*Maternal and Child Health Block Grant, Social Services Block Grant, Temporary Assistance to Needy Families, and others  
Source: The Guttmacher Institute<sup>29</sup>

## E. Publicly-Funded Family Planning Program Characteristics

The primary public programs that provide family planning services for teens and low-income women are Medicaid and Title X. In some cases states supplement these programs with federal block grant funds that provide more limited family planning services. This section summarizes the characteristics of these programs, as well as other supplemental block grant programs. The table on page 13 provides a comparison of Medicaid and Title X services, eligibility, service delivery, and funding structure.

**Medicaid.** In 1965, Congress established the federal Medicaid program to provide health insurance to low-income individuals. As a federal entitlement program administered by the states, Medicaid programs are jointly funded by states and the Federal Government. State programs must meet federal requirements for program eligibility and services.<sup>30</sup>

Eligibility for Family Planning Services Under Medicaid. In 1972, Congress passed a law that changed the family planning services states provide to Medicaid recipients from a state option to a state requirement. In effect, federal law mandates that states provide free family planning services to all recipients who qualify for full Medicaid coverage. As currently structured, the full Medicaid package of services – and thus mandated coverage for family planning services – are only available to limited populations (e.g., low-income families, children, adults with special needs, pregnant women, citizens, certain legal immigrants). Under the law, which remains in effect today, states must:

- Provide free family planning services, even if their programs usually require beneficiaries to contribute a co-pay;
- Include prescription coverage for contraceptives; and
- Allow participants to go outside of Medicaid managed care plans for family planning services.<sup>31</sup>

Although eligibility for full Medicaid coverage may vary widely from state to state, the Federal Government requires states, through Medicaid, to provide pregnancy-related care, including 60 days of postpartum family planning services, to all women with incomes up to 133% of the federal poverty level. Many women who

<sup>30</sup> U.S. DHHS Centers for Medicare and Medicaid Services. (n.d.) [www.cms.gov](http://www.cms.gov)

<sup>31</sup> Gold, et. al., (2007). *Medicaid's Role in Family Planning*

qualified for Medicaid when they became pregnant lose Medicaid coverage, including access to family planning services, two months after their child is born. (Their child continues to receive coverage through state children's health insurance programs.)<sup>32</sup>

Some states have received waivers from the Federal Government to implement expansion programs that allow them to extend family planning services to women who would otherwise not qualify for Medicaid coverage. Generally, state waiver programs expand access to family planning services by carving out special family planning-only coverage.<sup>33</sup> These waiver programs and their results are described in detail in Chapters 2 and 3.

**Federal Funding for Medicaid Family Planning Services.** Under federal law, the Federal Government reimburses states for a portion of their Medicaid program costs. The federal matching rate for family planning services is 90% of state family planning service costs. This rate is higher than a state's regular federal matching rate. For example, the 90% matching rate for family planning services is higher than Maryland's regular reimbursement rate of 50% of costs. It is also higher than Maryland's enhanced reimbursement rate of about 62% of costs which the State is receiving for the first half of FY11.<sup>34</sup>

**Federal Family Planning Services Guidelines.** Although federal law mandates that states provide free family planning services to recipients who qualify for full Medicaid coverage, neither federal law nor regulation establish a definition of family planning services. Instead, federal guidelines for services reimbursed at the 90% rate state that family planning services include:

- Counseling service and patient education;
- Examination and treatment by medical professionals in accordance with applicable state requirements;
- Laboratory examinations and tests;
- Medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception; and
- Infertility services, including sterilization reversals.<sup>35</sup>

As a result, decisions about what services state Medicaid programs may or may not provide as "family planning" can be challenging. For example, if STI testing is routinely performed during a family planning visit, the test can be considered family planning; however, if a patient needs treatment, the treatment is not considered family planning.<sup>36</sup>

**Title X.** When Title X of the Public Health Service Act was enacted in 1970, it created the sole federal grant program to fund only family planning services. This is still the case today. The Title X program is designed to give "access to contraceptive services, supplies, and information to all who want and need them" with priority given to low-income individuals. In addition, the program aims to help families plan the number and spacing of children and promote maternal and infant health.<sup>37</sup>

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<sup>32</sup> Guttmacher. (2010). *State Medicaid Family Planning Eligibility Expansions*

<sup>33</sup> Ibid.

<sup>34</sup> Gold, et. al., (2007). *Medicaid's Role in Family Planning*; Maryland Department of Legislative Services. (General Assembly 2010 Session). *HB 1358 Fiscal and Policy Note*

<sup>35</sup> U.S. DHHS Centers for Medicare and Medicaid Services. (n.d.) *State Medicaid Manual*

<sup>36</sup> Ibid.

<sup>37</sup> U.S. DHHS Office of Public Health and Science. (n.d.) *Family Planning*

Eligibility for Title X Family Planning Services. Title X funds subsidize care for clients whose income is 250% of the FPL or less. Clients pay for services on a sliding scale; people with very low incomes (i.e., below the FPL) receive free services while higher income patients pay a portion of the cost. In addition to women, Title X programs serve teens and men. Program eligibility is not subject to citizenship or immigration status requirements. Participants may also qualify based on personal income rather than family income when confidentiality and safety are a concern.<sup>38</sup>

Mandated Title X Family Planning Services. Title X grants are awarded to local health departments and private health clinics that meet Title X standards of care. By law, Title X services must be voluntary, confidential, affordable, and comprehensive, providing a variety of family planning methods as well as nondirective counseling.<sup>39</sup> Along with contraceptive services, Title X grantees must provide other reproductive preventive health services, including patient counseling and education; breast and pelvic exams; cancer screening; STI and HIV prevention counseling, testing, and referral for treatment; and pregnancy diagnosis and counseling.<sup>40</sup> In addition Title X may also support:

- Training for family planning clinic personnel;
- Data collection and family planning research; and
- Community education and outreach.<sup>41</sup>

Federal law prohibits Title X funding from being used for programs that provide abortion as a family planning method.<sup>42</sup>

Sources of Provider Funding Under Title X. Title X providers are funded through Title X grant funds and patient co-pays. Providers are also required to bill third-party insurance, including Medicaid, when a patient has coverage.

In recent years, Title X clinics have experienced cost pressures as funding has remained flat or decreased while costs have increased.<sup>43</sup> A 2006 report describes some specific examples of challenges clinics face:

- Clients are requesting newer contraceptive methods that are easier to use but more expensive;
- Clinics are spending more on diagnostic tests due to both increased demand and higher per test costs;
- Clinics are not reimbursed for the full cost of providing care to Medicaid-insured patients, and decreasing buying power makes it more difficult for clinics to cover the difference with Title X funds;
- Clinics use Title X funds to cover costs of services that may not be paid for under Medicaid family planning programs (e.g., STI or HIV testing); and
- Clinics face increasing demand and costs for language assistance for non-English speaking clients.<sup>44</sup>

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<sup>38</sup> Frost, et. al., (2006). *Estimating the Impact of Serving New Clients by Expanding Funding for Title X*; Bonnie Birkel, DHMH Family Health Administration, Personal Communication.

<sup>39</sup> Frost, et. al., (2006). *Estimating the Impact of Serving New Clients by Expanding Funding for Title X*

<sup>40</sup> U.S. DHHS Office of Public Health and Science. (n.d.) *Family Planning*

<sup>41</sup> Ibid.

<sup>42</sup> Ibid.

<sup>43</sup> Sonfield, et. al., (2008). *Public Funding for Family Planning, Sterilization, and Abortion Services, FY 1980-2006*

<sup>44</sup> Sonfield, et. al., (2006). *Cost Pressures on Title X Family Planning Grantees, FY 2001-2004*; Gold. (2007). *Stronger Together*

**Table 1-5: Comparison of Medicaid and Title X**

Medicaid	Title X
<b>Services</b>	
<p><u>May</u> include:</p> <ul style="list-style-type: none"> <li>• Contraceptive supplies and services, including sterilization</li> <li>• Patient counseling and education</li> <li>• Breast and pelvic exams</li> <li>• Cancer screening</li> <li>• STI and HIV prevention counseling, testing, and referral for treatment</li> <li>• Pregnancy diagnosis and counseling</li> </ul>	<p><u>Must</u> include:</p> <ul style="list-style-type: none"> <li>• Contraceptive supplies and services, including sterilization</li> <li>• Patient counseling and education</li> <li>• Breast and pelvic exams</li> <li>• Cancer screening</li> <li>• STI and HIV prevention counseling, testing, and referral for treatment</li> <li>• Pregnancy diagnosis and counseling</li> </ul>
<b>Eligibility</b>	
<ul style="list-style-type: none"> <li>• States must provide family planning service to individuals to qualify for full Medicaid coverage</li> <li>• States set Medicaid eligibility rules based on income, family size, and other factors within federal guidelines</li> <li>• Individuals must meet federal standards for citizenship or legal residency</li> </ul>	<ul style="list-style-type: none"> <li>• Women and men with incomes below 100% of the FPL qualify for free services</li> <li>• Women and men with incomes from 100% - 250% of the FPL pay on a sliding-scale fee</li> <li>• Women and men with higher incomes may receive services but pay full cost</li> <li>• No citizenship or legal residency requirements</li> <li>• Services can be provided in a confidential manner (i.e., teens can receive services without parental involvement)</li> </ul>
<b>Service Delivery</b>	
<ul style="list-style-type: none"> <li>• Services provided by private physicians, private clinics, or publicly funded clinics that accept Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>• Services provided only by certified Title X clinics that agree to meet standards of care</li> </ul>
<b>Funding Structure</b>	
<ul style="list-style-type: none"> <li>• Funded by state and the Federal Government</li> <li>• Funding expands to meet the need</li> </ul>	<ul style="list-style-type: none"> <li>• Funded by federal grant, insurance (including Medicaid), and client co-pays</li> <li>• Funding is limited</li> </ul>

**Complementary Nature of Medicaid and Title X.** Medicaid and Title X provide similar services but have different eligibility standards, service delivery structures, and funding structures. Overall, the programs complement each other with different strengths.

- Title X providers must offer the full range of reproductive health services to clients who come to a family planning visit. Medicaid providers may offer the full range of services, but the Title X requirement means that the level of care is standardized.
- Title X has broader eligibility standards that encompass men and women regardless of age, income, and citizenship/immigration status. In addition, the program can provide confidential services to teens and women who may not be able to use their private insurance for safety reasons. Unless states have Medicaid expansion programs, most state's eligibility standards are much more limited.

- Medicaid has a broader base of providers, where Title X is limited to certified clinics.
- Medicaid funds expand to meet the need as enrollment increases; Title X is limited by grant funds, insurance payments, and client co-pays.

The funding structures for Medicaid and Title X provide an opportunity for the two programs to work together financially and increase access to care. Specifically, if Medicaid eligibility expands, more women who receive their care at Title X clinics could be covered by insurance. This would allow the clinics to collect Medicaid reimbursement for their care, reducing the amount of Title X funds clinics need for this population. Instead, Title X funds could be used to care for additional clients who are not covered by Medicaid or for other Title X activities (e.g., education and outreach) that can contribute to reproductive health and reducing unintended pregnancy rates.<sup>45</sup>

**Other Publicly-Funded Family Planning Programs.** Three other federal programs provide public funds for limited family planning services. For example, a small portion of public expenditures for family planning come from the Federal Maternal and Child Health Block Grant, Social Services Block Grant, and Temporary Assistance to Needy Families, described below.

Maternal and Child Health Block Grant. Title V of the Social Security Act authorizes block grants to states to support programs that improve the health of mothers and children. Among other uses, states may use this funding for direct health care services, including family planning.<sup>46</sup>

Social Services Block Grant. Title XX of the Social Security Act authorizes Social Services Block Grants. States may use these grants for a wide variety of social services, including health-related services for family planning.<sup>47</sup>

Temporary Assistance to Needy Families. Title VI of the Social Security Act authorizes block grants to the states for Temporary Assistance to Needy Families. This program is most well-known for providing cash assistance to needy families with children. However, some of the funds can be used for other services, including pre-pregnancy family planning services.<sup>48</sup>

Currently, Maryland does not use any of these block grants for family planning services.<sup>49</sup>

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<sup>45</sup> Gold. (2007). *Stronger Together*

<sup>46</sup> Guttmacher. (2000). *Fulfilling the Promise*

<sup>47</sup> Ibid.

<sup>48</sup> Federal Grants Wire. (n.d.) *Temporary Assistance for Needy Families*

<sup>49</sup> Sonfield, et. al., (2008). *Public Funding for Family Planning, Sterilization, and Abortion Services, FY 1980-2006*

## **CHAPTER 2. Medicaid Waivers for Family Planning Program Expansions**

As described in Chapter 1, federal law requires states to provide free family planning services to women who qualify for full Medicaid coverage. However, income eligibility limits restrict Medicaid coverage to only a small portion of more than 17 million teens and women who need publicly-funded services, under the Guttmacher Institute's definition of need. To address this shortfall in services, some states, including Maryland, have established Section 1115 waiver programs that expand coverage for family planning services to populations that do not otherwise qualify for Medicaid.

This chapter responds to the Council's request for a better understanding of the different approaches states' waiver programs use to expand access to family planning services. It also describes what the research evaluation literature says about what works and offers insights from the research literature about implementation practices. Specifically:

**Section A** describes three types of waiver programs states have used to expand coverage for family planning services;

**Section B** summarizes available research findings about the impact of waiver programs; and

**Section C** presents implementation practices states use to improve waiver program access.

### **A. Overview of Medicaid Waivers for Family Planning Services**

Since 1993, 27 states have received "Section 1115 waivers" from the Centers for Medicare and Medicaid Services (CMS) to expand family planning coverage to women who would not otherwise qualify for services under Medicaid. These waiver programs must further the goals of Medicaid and be cost neutral to the Federal Government.<sup>1</sup>

**Waiver Program Designs.** The 27 state family planning waiver programs use different approaches to expand eligibility for family planning services. The programs can be grouped into three broad categories:

- Expanded income-based eligibility for family planning services. This is the most widely used approach, and it offers the broadest eligibility for family planning services. Twenty-one states provide family planning services for women whose incomes exceed the state limit for full Medicaid coverage. States have established income limits that range from 133% to 200% of the FPL.
- Continuation of family planning services after any loss of Medicaid. This approach offers a moderate expansion of services, allowing women who lose Medicaid for any reason, including following a Medicaid-funded birth, to continue receiving family planning services. Two states have adopted this approach and provide the extended benefits for up to two years.
- Extended postpartum-coverage. This approach offers the most limited expansion of benefits, expanding eligibility only to those women who would otherwise lose coverage after a Medicaid-funded birth. Instead of losing benefits at 60 days postpartum, women may continue receiving family planning services for a longer time (program length varies from two years to unlimited). Maryland has this type of waiver, described in detail beginning on page 25.<sup>2</sup>

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<sup>1</sup>Guttmacher. (2010). *State Medicaid Family Planning Eligibility Expansions*; U.S. DHHS Centers for Medicare and Medicaid Services. (n.d.) *Medicaid State Waiver Demonstration Projects – General Information*; Sonfield, et. al., (2008). *State Government Innovation in the Design and Implementation of Medicaid Family Planning Expansions*

<sup>2</sup> Guttmacher. (2010). *State Medicaid Family Planning Eligibility Expansions*

Beyond expanding eligibility for women, some states' waiver programs expand eligibility for free family planning services to other groups. For example, eight states provide family planning services to men; and 16 states extend eligibility to minors. (11 states limit eligibility to clients who are at least 18 or 19 years old.)<sup>4</sup>

When CMS grants a waiver, it allows a state to collect federal Medicaid reimbursement for services that would not otherwise qualify. States that have waiver programs in place are reimbursed at 90% of the cost of federally qualified family planning services that they provide (see list of services on page 11). If a state's family planning program offers additional non-qualified services (e.g., STI treatment), the costs of these services are reimbursed at the state's regular reimbursement rate.<sup>5</sup> For example, Maryland's family planning program provides treatment for STIs (other than HIV) and other diagnoses which are not considered family planning services by the Federal Government. Under the current waiver, Maryland is reimbursed at the regular federal matching rate of 50% for these services.<sup>6</sup>

Appendix C provides a table that lists all state plans and summarizes key characteristics of the plans.

## **B. Medicaid Waiver Evaluation Research Results**

Several studies have examined the effectiveness of Medicaid family planning waiver programs. This section reports findings from multiple studies, plus findings from evaluations of Wisconsin's, South Carolina's, and Alabama's state programs.

Overall, the studies conclude that the programs help expand access to family planning services and result in significant cost savings for states and the Federal Government. Current research about the impact of waiver programs on unintended pregnancy rates is less conclusive.

**Waiver Programs Expand Access to Family Planning Services.** A primary goal of family planning waiver programs is to expand access to family planning services. A 2003 study commissioned by the Centers for Medicaid and Medicare Services (CMS) that considered family planning waiver programs in six states – Alabama, Arkansas, California, New Mexico, Oregon, and South Carolina – found mostly positive trends in this area. Specifically:

- Researchers compared the number of women served by the Medicaid waiver programs to the number of women previously served by Title X clinics who would have been eligible for the waiver program if it had existed. In four out of the six states studied, more women were served by the Medicaid waiver program than had been served by Title X.
- The waiver program increased geographic availability of family planning services through private physicians and other non-Title X clinics in all six states.
- In five of the six states, roughly one quarter to one half of eligible women accessed services through the waiver program. Only one state had a very low participation rate (only 8% of eligible women received services).<sup>7</sup>

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<sup>4</sup> Ibid.

<sup>5</sup> Sonfield, et. al., (2008). *State Government Innovation in the Design and Implementation of Medicaid Family Planning Expansions*

<sup>6</sup> U.S. DHHS Centers for Medicare and Medicaid Services. (n.d.) *HealthChoice Medicaid Services Section 1115 Demonstration*

<sup>7</sup> Guttmacher (January 26, 2004). *CMS Study of Medicaid Family Planning Waiver Program*



An evaluation of Alabama's income-based family planning waiver program found that from 2000 to 2005, the number of non-Title X sites participating in the family planning expansion program increased from 177 to 1,160.<sup>8</sup>

A 2008 study by Frost, Frohwirth, and Purcell examined whether different program designs were more effective at expanding access to family planning services. The results indicate that income-based waivers were more effective than other types of waivers. Specifically:

- From 1994 to 2001, the number of clients served by family planning clinics increased an average of 24% in states that implemented income-based waivers during that time.
- States that did not implement a waiver during that time saw an average of a 2% decrease in clients served; and states with other types of family planning waivers saw an average decrease of 8%.
- In Maryland – a state with a postpartum-based waiver – the number of clients seen by all publicly-funded clinics dropped by 22.3% from 1994 to 2001. The number of women seen by only Title X clinics dropped 1.1% during this time period.<sup>9</sup>

The Frost study also considered the relationship between the existence and design of state waiver programs and the percent of need met by publicly-funded clinics. Researchers estimated that:

- In states with income-based waivers, clinics met, on average, 27% more need in 2001 than 1994.
- In states without waivers, the percent of need met remained steady at about 40%.
- In states with postpartum- or other Medicaid loss-based waivers, the percent of need met decreased by an average of 4%. In Maryland, the percentage of need met by all publicly-funded clinics dropped by 17.9% from 1994 to 2001, but the percentage of need met by only Title X clinics increased 4.6% during this time period.<sup>10</sup>

**Medicaid Family Planning Waiver Programs Can Reduce Overall Medicaid Costs.** Studies demonstrate that family planning waiver programs save states and the Federal Government money because the cost of providing family planning services is less than the cost of a Medicaid-funded birth and subsequent health care for an infant. Savings are not achieved in the first nine months to a year of the family planning program. Instead savings from the programs' cost differential accrue over time as family planning enrollment increases and unintended births are averted.

The estimates of cost savings vary widely. It can be difficult to quantify how much money the expansion of family planning services saves because estimates are based on assumptions about averted births and subsequent savings on pregnancy related care and infant care.<sup>11</sup>

A 2008 study by Frost, Finer, and Tapales estimates that states and the Federal Government save, on average, about four dollars for every dollar spent on family planning by publicly-funded clinics (both

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<sup>8</sup> Bronstein, J.M. (2006). *Alabama Plan First Evaluation*

<sup>9</sup> Frost, et. al., (2004). *Availability and Use of Publicly Funded Family Planning Clinics*

<sup>10</sup> Ibid.

<sup>11</sup> Averted births are typically estimated using complex formulas involving the number of enrolled women, data on types of birth control methods used, and data on birth control method success/failure rates.

Medicaid and Title X). These saving estimates are based on foregone costs for both maternal pregnancy-related care and the first year of health care for an infant.<sup>12</sup>

The 2003 CMS study of waiver programs found that all six states realized savings when the cost of the family planning program was compared to the cost of Medicaid-funded maternity care and one year of infant care for averted births.<sup>13</sup>

A later study analyzed the cost savings for all of these programs except Alabama's. It found that the savings in Arkansas, New Mexico, and Oregon were statistically significant; that California's savings were large (\$43 million from 1999-2001), but not statistically significant; and that South Carolina, which switched from a postpartum-based to an income-based waiver during the study period, had minimal savings (about \$1.8 million from 1994-1997).<sup>14</sup> More recent data from South Carolina show cost savings of \$17.3 million in 2005 alone.<sup>15</sup>

Individual state evaluations also provide estimates of waiver program savings. For example, Wisconsin's family planning waiver provides family planning services for women with incomes up to 185% of the FPL. An evaluation of this program reported that the program served 69,000 women at a cost of \$48.2 million over a four-year period (2003-2006). Evaluators estimate the program averted more than 37,000 births. This study estimated the program savings at \$487 million over the four-year period; however, this estimate was based on the cost of a Medicaid birth plus five years of child health care costs. Using the more common measure of the cost of a Medicaid birth plus one year of child health care costs, the estimated program savings would be about \$354 million over the four-year period.<sup>16</sup>

**Evidence that Waiver Programs Reduce Unintended Pregnancy Rates Less Conclusive.** Another goal of some waiver programs is to reduce unintended pregnancy rates among the target population. Although there is some evidence that programs may meet this goal, evaluation results for individual state programs are inconclusive.

A 2007 study considered birthrates in states with income-based waivers, postpartum-based waivers, and states with no expansion. The study found that states with income-based expansions experienced statistically significant decreases in birthrates compared to states with no expansion. At the same time, states with postpartum-based waivers experienced decreased birthrates, but the changes were not statistically significant.<sup>17</sup>

An evaluation of Alabama's income-based waiver program studied the impact of the program on birthrates among women statewide, among women with Medicaid births, and among program enrollees from 2000-2005. The researchers found that while the statewide birthrate was unaffected, data showed that the Medicaid birthrate declined slightly. The greatest impact was found among program enrollees, specifically:

- Enrollees who received family planning services had a significantly lower birthrate than those who did not receive services; and

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<sup>12</sup> Frost et. al., (2006). *Estimating the Impact of Serving New Clients by Expanding Funding for Title X*

<sup>13</sup> Guttmacher (January 26, 2004). *CMS Study of Medicaid Family Planning Waiver Program*

<sup>14</sup> Lindrooth, et. al., (2007). *The Effect of Medicaid Family Planning Expansions on Unplanned Births*

<sup>15</sup> Center for Health Services & Policy Research. (2007). *SC Family Planning Waiver*

<sup>16</sup> Wisconsin Department of Health and Family Services. (2008). *The Wisconsin Family Planning Waiver: Final Evaluation Report for 2003-2007*

<sup>17</sup> Lindrooth, et. al., (2007). *The Effect of Medicaid Family Planning Expansions on Unplanned Births*

- Women who participated in risk assessments (e.g., counseling and appointment reminders) had lower birthrates than other enrollees who received services.<sup>18</sup>

In contrast, an evaluation of Wisconsin's waiver program is inconclusive. Specifically:

- Wisconsin compared the rate of Medicaid-funded births for women at or below 185% of the FPL before and after implementing the program and found an increase in the Medicaid birthrate. However, since only about 25% of women with incomes at or below 185% of the FPL participated in the family planning waiver program, this may not be a good indication of the effectiveness of the program for participants.
- Wisconsin compared teen pregnancy rates before and after program implementation. Overall, the birthrate for all teens with incomes below 185% of the FPL dropped; however, this trend had started before the program began and evaluators could not determine what effect the program had on the continued decrease. Still, a comparison of birthrates of program participants, all low-income teens, and all teens shows that teen program participants had a lower birthrate than other groups.<sup>19</sup>

An evaluation of South Carolina's waiver program showed no difference in pregnancy intention between family planning waiver program participants and non-participants among women with incomes at or below 185% of the FPL who had a live birth between 1993 to 2003. Still, South Carolina estimates that the program decreased the fertility rate among program participants, resulting in more than 25,000 averted pregnancies from 1995 to 2005.<sup>20</sup>

Although these studies do not demonstrate a clear impact of waiver programs on unintended pregnancy rates, previous research on publicly-funded family planning clinics confirms that publicly-funded programs help teens and low-income women avert unintended pregnancies (see page 7).

## **B. Variations in States' Waiver Program Implementation Practices**

OLO found little research on the effects of specific program implementation features on program outcomes; however, the research literature does offer useful descriptive information about states' implementation practices, including outreach strategies and enrollment procedures. This section summarizes some of the variations among waiver programs. Unless otherwise noted, the information in this section is attributable to *State Government Innovation and Design in Implementation of Family Planning Medicaid Expansions*, a 2008 report by the Guttmacher Institute. Table 2-1 on page 22 lists sample features of selected state family planning expansion programs gathered from the states' program websites.

**Outreach.** States' outreach strategies target both clients and health care providers. For clients, states make limited use of mass media campaigns when the program is first implemented. Once a program is established, states focus targeted outreach on high-risk clients, such as women who may be losing coverage postpartum or women who are applying for other public benefits. States also work with college and university campuses, participate in health fairs, and assign outreach teams to areas of the state with low program enrollment. State websites also help provide information about family planning programs.

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<sup>18</sup> Bronstein, J.M. (2006). *Alabama Plan First Evaluation*

<sup>19</sup> Wisconsin Department of Health and Family Services. (2008). *The Wisconsin Family Planning Waiver: Final Evaluation Report for 2003-2007*.

<sup>20</sup> Center for Health Services & Policy Research. (2007). *SC Family Planning Waiver*

States' provider outreach strategies address recruitment and training. Outreach strategies to recruit providers vary based on the structure of a state's provider system. Some states can automatically integrate current Medicaid providers into a new family planning provider system, while other states must enroll providers individually because the state separates the operation of its family planning and Medicaid programs. In all cases, however, recruitment of new providers helps expand the reach of family planning services in the state.

Some states, such as Oregon, first established the program using their Title X clinic network and later expanded the program to other public and private providers.<sup>21</sup>

States' techniques for training Medicaid providers about the waiver program or changes to the program vary. Common strategies include disseminating bulletins to providers and medical associations; training meetings; video conferences; and web-based training tools.

Although the Federal Government reimburses states for some outreach activities, states also use Title X grant dollars to fund outreach efforts for their Medicaid waiver programs.

**Application and Enrollment Practices.** Waiver programs must identify potential clients and compile information to determine a client's eligibility for services. States' practices vary, but all are intended to ease the application process for family planning waiver programs. Some common practices include automatic enrollment, simplified one-page application forms, on-site enrollment at a clinic, or assistance with accessing documentation.

- Some states automatically enroll women who are losing other Medicaid coverage (e.g., due to child birth, increased income, or aging out of the children's health program) directly into the family planning program. However, automatic enrollment alone does not guarantee high participation rates. Instead, without significant outreach to the women who are automatically enrolled, service utilization can be low either because women are not aware that they are enrolled or do not know what services they can receive. For example, Alabama's waiver program uses automatic enrollment for some women. An evaluation of the program showed that about half of enrolled women accessed services; however, a survey of women enrolled in the program showed that 40% did not know they were enrolled in the program.<sup>22</sup>
- Some states automatically screen women who apply for other public programs and offer them the opportunity to enroll if they are eligible.
- Some states use simplified one-page applications plus state and private databases to verify income and citizenship.
- A few states allow clients to enroll at clinics, resulting in expedited service delivery.
- Some states assist clients with accessing documentation – such as birth certificates – at no cost to the client.<sup>23</sup>

When states allow clients to apply for a family planning program at a clinic, clients can often apply and receive services on the same day. States have implemented this practice in a variety of ways.

- In some cases, clients receive temporary "presumptive" eligibility and can receive same-day services that are reimbursed by the waiver program.

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<sup>21</sup> Oregon Department of Human Services. (2006). *Family Planning Manual*

<sup>22</sup> Bronstein, J.M. (2006). *Alabama Plan First Evaluation*

<sup>23</sup> Guttmacher. (2010). *State Medicaid Family Planning Eligibility Expansions*

- Other states provide training to clinic staff so that they can access the state's database and officially enroll a client on-site.
- Some states guarantee funding for a first visit while the client's application is pending.

Even without presumptive eligibility or guaranteed reimbursement from the state, some clinics will help a client enroll and wait to be reimbursed when the application is approved, even though they risk losing money if the client is found ineligible for services. A few states have made arrangements to reimburse providers for the cost of helping with applications.

**Practices that Protect Confidentiality.** Some states have taken specific steps to protect the confidentiality of family planning program participants, particularly for teens and for women who are at risk of abuse. These steps include:

- Permitting participants to supply an alternate mailing address and phone number so they can be contacted privately;
- Allowing privately insured women to enroll if they fear that making a claim could put them in danger of abuse; and
- Issuing no benefit card or a card that is the same as or very similar to a regular Medicaid card so that it is not obvious the participant is enrolled in a family planning program.

**Service Eligibility for Teens.** Sixteen states' waiver programs extend eligibility for family planning services to women who are under 18 or 19 years old.<sup>24</sup> Studies indicate that many teens will not seek family planning services if a parent must be involved. In response, some state's practices either allow teens to qualify based on their own income and/or allow teens to waive parental notification requirements. For example, Wisconsin, Arkansas, and California allow teens to qualify for Medicaid family planning services based on their personal income, instead of the income of their parents.

**Service Eligibility for Men.** According to the Guttmacher Institute, in 2002 only 30% of men age 20-44 (of any income level) received a reproductive health service.<sup>25</sup> Eight states' waiver programs extend eligibility for family planning services to men.<sup>26</sup> Services to men frequently include education and counseling, barrier method contraceptives, and sterilization services.

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<sup>24</sup> Ibid.

<sup>25</sup> Gold, et. al., (2009). *Next Steps for America's Family Planning Program*

<sup>26</sup> Guttmacher. (2010). *State Medicaid Family Planning Eligibility Expansions*

**Table 2-1: Sample Features of State Medicaid Family Planning Expansion Programs**

State	Selected Program Features
Alabama <sup>27</sup> - Plan First <ul style="list-style-type: none"> <li>Women age 19-55, up to 200% FPL</li> </ul>	<ul style="list-style-type: none"> <li>Hotline informs enrollees about participating health care providers</li> <li>Automatically enrolls (1) women whose children qualify for the state's children's health insurance program and (2) women who are losing Medicaid postpartum</li> <li>Provides care coordination, including additional counseling and appointment reminders, for women at high-risk of unintended pregnancy</li> </ul>
California <sup>28</sup> – FamilyPACT <ul style="list-style-type: none"> <li>Women, men, and teens, up to 200% FPL</li> </ul>	<ul style="list-style-type: none"> <li>On-site enrollment</li> <li>Eligibility not based on immigration status (The state funds services for individuals not covered by federal law.)</li> <li>Teens are eligible <i>independent of</i> family income or parental consent</li> </ul>
Minnesota <sup>29</sup> – Family Planning Program <ul style="list-style-type: none"> <li>Women and men age 15-50, up to 200% FPL</li> </ul>	<ul style="list-style-type: none"> <li>Certified providers can enroll clients with “presumptive eligibility” that allows participants to receive services for 30 days while they apply for “continuing eligibility”</li> </ul>
Oregon <sup>30</sup> – Family Planning Expansion Program <ul style="list-style-type: none"> <li>Women and men, up to 185% FPL</li> </ul>	<ul style="list-style-type: none"> <li>On-site enrollment at clinic sites</li> <li>Began with only Title X clinics, started enrolling other providers later</li> <li>All providers agree to meet standards of care that require counseling and education, comprehensive exam including STI and other testing, and comprehensive contraceptive offerings</li> <li>Participants may receive one visit without documentation of citizenship; state will assist with obtaining out-of-state birth certificates</li> <li>Program <i>does not</i> cover treatment for STIs or other infections or sterilizations</li> </ul>
Rhode Island <sup>31</sup> – Rite Care <ul style="list-style-type: none"> <li>Women losing Medicaid postpartum, up to 200% FPL</li> </ul>	<ul style="list-style-type: none"> <li>\$2 co-pay for office visits, a \$1 co-pay for contraceptives, and a \$15 co-pay for sterilization services</li> </ul>
Wisconsin <sup>32</sup> – BadgerCare Plus <ul style="list-style-type: none"> <li>Women age 15-44, up to 200% FPL</li> </ul>	<ul style="list-style-type: none"> <li>Women may receive family planning services from any Medicaid family planning provider, however certain “qualified providers” may determine presumptive eligibility</li> </ul>

<sup>27</sup> Alabama Medicaid Agency. (n.d.) *Plan First Program*.

<sup>28</sup> California Department of Public Health. (2008) *Fact Sheet on Family PACT: An Overview*

<sup>29</sup> Minnesota Department of Health. (n.d.) *The Minnesota Family Planning Program*

<sup>30</sup> Oregon Department of Human Services. (2006). *Family Planning Manual*

<sup>31</sup> U.S. DHHS Centers for Medicare and Medicaid Services. (2009). *Rhode Island Rite Care Section 1115 Demonstration Waiver Fact Sheet*

<sup>32</sup> Wisconsin Department of Health and Family Services. (2009.) *BadgerCare+ Family Planning Waiver Plan*

## CHAPTER 3. Publicly-Funded Family Planning Services in Maryland and Montgomery County

As reported in Chapter 1, the Guttmacher Institute estimates that 258,560 women and teens in Maryland, including 30,560 in Montgomery County, were in need of publicly-funded family planning services in 2006. Title X, Medicaid, Medicaid waiver programs, and other publicly-funded local programs create the provider network of family planning coverage for these women, but disparities in unintended birthrates indicate that many women still do not have adequate access to family planning services.

This chapter provides an overview of publicly-funded family planning services in Maryland and Montgomery County. A summary table of these programs appears at the end of this chapter (page 30-31).

**Section A** summarizes Maryland State Medical Programs that provide family planning services, including eligibility rules and the specific services provided;

**Section B** describes Montgomery County-funded medical programs that fund some family planning or related services; and

**Section C** provides results from research on Maryland family planning programs.

### A. Maryland State Medical Programs

Title X and Medicaid establish the primary framework for delivering family planning services to low-income women in Maryland. To supplement these “basic” Title X and Medicaid programs, Maryland’s Section 1115 Medicaid waiver offers expanded family planning coverage through two programs – the Family Planning Program and the Primary Adult Care Program. This section describes the basic services Maryland offers under Title X and Medicaid, plus the supplemental services provided under its two Section 1115 waiver programs.

#### 1. “Basic” Family Planning Programs and Services

Maryland’s “basic” family planning programs include Title X clinic services and full Medicaid coverage for qualified children and adults. While Title X services are available to any man, woman, or teen in the State, Medicaid eligibility is more limited. On the other hand, Title X family planning services are only available at certified clinics, while Medicaid family planning can be provided by any participating clinic or private physician.

**Title X.** In FY10, Maryland appropriated \$12.32 million to fund the Title X program; including \$4.26 million in federal funds and \$8.06 million in State general funds. The program is nearly level-funded for FY11 at \$12.33 million, with the slight increase due to additional federal funds. The State is required to match 10% of federal funds; currently State appropriations exceed the requirement. The additional funds support teen pregnancy programs and contraceptive and lab costs.<sup>1</sup>

State grants to local health departments and other designated agencies (e.g., Planned Parenthood of Maryland) that provide Title X family planning services served about 75,000 women statewide in FY10. Approximately 30% of clients were under age 20, and only 10% had any type of Medicaid coverage.<sup>2</sup>

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<sup>1</sup> Maryland Department of Legislative Services. (General Assembly 2010 Session). *HB 1358 Fiscal and Policy Note*; Bonnie Birkel, DHMH Family Health Administration, Personal Communication.

<sup>2</sup> Bonnie Birkel, DHMH Family Health Administration, Personal Communication.

The Family Health Administration in the Public Health Services Division of DHMH administers the program. Both women and men are eligible for Title X family planning services. Providers charge participants a fee for service based on their incomes. Services are free for participants with incomes under 100% of the FPL, and those with incomes over 250% of the FPL pay full cost. The Family Health Administration reports that most participants have incomes of 150% of the FPL or less. No proof of income or citizenship or immigration status is required.<sup>3</sup>

The Family Health Administration reports that the cost of care for each Title X participant is about \$250 annually. Title X grants subsidize about half that amount, and providers rely on multiple sources to cover their remaining costs. Historically, many county health departments have used core services funds from the State to cover the difference; however, the State has made cuts of up to 45% in these funds in recent years. Providers must also bill third party insurers, such as Medicaid, to help cover their costs.<sup>4</sup>

**Medicaid.** Maryland's Medicaid programs are administered by the Health Care Financing Division of DHMH. Individuals who qualify for full Medicaid coverage are eligible for family planning services; they may receive family planning services at their choice of Medicaid provider, and there is no co-pay for contraceptives. However, a set of complex eligibility rules limits full Medicaid coverage for adults in Maryland to the following groups:

- Adults with dependent children whose incomes do not exceed 116% of the FPL;
- Young adults age 19 to 21 whose incomes do not exceed 116% of the FPL;
- Pregnant women with incomes up to 250% of the FPL;
- Adults who are aged, blind, or disabled and meet other eligibility criteria; and
- Adults who meet criteria for being "medically needy" or receive Social Security Disability Insurance, or adults and children with special needs who meet certain income and asset criteria.<sup>5</sup>

Childless adults without special needs cannot qualify for full Medicaid. In addition, only legal immigrants who meet specific criteria (e.g., children, pregnant women, refugees, asylees, or permanent residents residing in the U.S. for five years) may be eligible for full Medicaid coverage.<sup>6</sup>

Children and young women under age 19 qualify for full Medicaid coverage under the Maryland Children's Health Program (MCHP) if their family income is equal to or less than 200% of the FPL. If a family's income is greater than 200% of the FPL but no more than 300% of the FPL, the family may pay a premium to enroll children in the MCHP.<sup>7</sup>

In sum, low-income adolescent girls and women seeking access to family planning services can either locate a Title X grantee that provides fee-based services with charges based on a sliding income scale, or qualify for full Medicaid coverage, including family planning services, based on their age and household income. Teens on MCHP have access to family planning services until their 19<sup>th</sup> birthday. From age 19 to 21, young adults qualify for full Medicaid if their income is up to 116% of the FPL. After 21, eligibility for Medicaid coverage depends on (1) having children and being very low-income, (2) being pregnant with an income up to 250% of the federal poverty level, or (3) meeting other criteria.

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<sup>3</sup> Maryland Department of Legislative Services. (General Assembly 2010 Session). *HB 1358 Fiscal and Policy Note* Gold, R.B. (2000) *Title X: Three Decades of Accomplishment*; Bonnie Birkel, DHMH Family Health Administration, Personal Communication.

<sup>4</sup> Bonnie Birkel, DHMH Family Service Administration, Personal Communication.

<sup>5</sup> Maryland DHMH (n.d.) *Medical Care Programs Eligibility*; Tricia Roddy, DHMH Office of Planning, Personal Communication

<sup>6</sup> Maryland DHMH (n.d.) *Medical Care Programs Eligibility*

<sup>7</sup> Ibid.



## 2. Maryland's Section 1115 Waiver Programs

In Maryland, low-income women who do not otherwise qualify for full Medicaid coverage can access family planning services through two Medicaid waiver expansion programs: the Family Planning Program and the Primary Adult Care Program.

**Background.** Maryland applied for and received a Section 1115 Medicaid Demonstration Waiver in 1995 to implement the State's Family Planning Program. In 2003, the Family Planning Program was incorporated into the State's broader 1115 HealthChoice waiver (first implemented in 1996) that creates a managed care program for Maryland's Medicaid program. In 2006, the 1115 waiver was further expanded to include the newly created Primary Adult Care Program.<sup>8</sup>

The Federal Government allows states to seek an initial five-year authorization, followed by three-year reauthorizations. After the initial five-year period expired, Maryland subsequently received approval to extend its waiver three times. The most recent extension, approved in 2008, will expire June 30, 2011. The State has submitted an application to extend the waiver for another three years.<sup>9</sup>

The Health Care Financing Division of DHMH administers the Medicaid expansion programs.

**Medicaid Waiver Family Planning Program.** Maryland's Medicaid Waiver Family Planning Program provides family planning services to postpartum women with incomes from 116% to 200% of the FPL who would otherwise lose full Medicaid coverage after giving birth.<sup>10</sup> After delivery, women who do not qualify or have not applied for full coverage are automatically enrolled in the Family Planning Program for one year. Women may renew their enrollment annually for up to four additional years if they remain income eligible.<sup>11</sup>

In response to directives from CMS, the State has changed both the waiver program's income eligibility guidelines and administrative practices over the years. Specifically,

- Between 1995 and 2008, the State set the income eligibility guidelines for the waiver program at the FPL which matched the State's eligibility limit for Medicaid coverage for pregnant women. (From 1995 to 2001 the income standard for pregnant women was 185% of the FPL. In 2001 it was increased to 250% of the FPL.) When the State requested reauthorization of the waiver program in 2008, CMS required the State to reduce income eligibility guidelines for the waiver program from 250% to 200% of the FPL. CMS also stipulated that women with other third party insurance could no longer be enrolled in the Family Planning Program.
- Prior to 2005 women were enrolled in the program for five years unless they became eligible for full Medicaid. From 2005 to 2008, eligibility was recertified annually but women only needed to indicate their income had not changed to maintain their enrollment in the program. In 2008, CMS instructed the State to change their administrative practices to require women to re-enroll annually.<sup>12</sup>

The State's recently submitted application to extend the program requests the program's eligibility rules be restored to the pre-2008 rules.<sup>13</sup>

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<sup>8</sup> U.S. DHHS Centers for Medicare and Medicaid Services. (n.d.) *Details for Maryland Health Choice 1115*; Alice Middleton, DHMH Office of Planning, Personal Communication

<sup>9</sup> U.S. DHHS Centers for Medicare and Medicaid Services. (n.d.) *Details for Maryland Health Choice 1115*; Tricia Roddy, DHMH Office of Planning, Personal Communication

<sup>10</sup> Women with incomes up to 116% of the FPL qualify for full Medicaid, including family planning services, if they have a dependent child.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

<sup>13</sup> Tricia Roddy, DHMH Office of Planning, Personal Communication

Women who are enrolled in the Medicaid Family Planning Program are eligible for:

- Preconception health care as part of a family planning visit;
- Reproductive health care, such as breast and cervical cancer screening and STI testing done in the context of a family planning visit;
- Treatment for STIs that are diagnosed in a family planning visit; and
- Contraceptive methods, including surgical procedures such as permanent sterilization.<sup>14</sup>

The federal reimbursement rate for Maryland's Family Planning Program varies depending on the service provided. On average, DHMH reports the State receives federal funds for about 80% of program costs. The costs for services that are considered "family planning services" (e.g., preconception care, contraceptives, and testing) are reimbursed at the 90% federal matching rate. Administrative costs<sup>15</sup> and the costs for "family planning related services" (e.g., treatment or follow-up testing for a condition diagnosed during a family planning visit) are reimbursed at the State's regular federal matching rate.<sup>16</sup> Total expenditures in FY09 were \$3.4 million.<sup>17</sup>

A recent evaluation of Maryland's Medicaid waiver program shows declining enrollment and low program participation rates (Table 3-1).

- Between 2004 and 2009, enrollment declined from about 56,000 to 16,000 participants.
- Enrollment declined steadily between 2004 and 2008. Some of this decline reflects women who enrolled in the Adult Primary Care Program in 2006 and an expansion that allowed adults with dependent children to qualify for full Medicaid beginning in 2008. Both of these programs extended coverage to women with incomes up to 116% of the FPL.
- Three program design factors contributed to 20,000 fewer enrollees at the end of 2009 than at the end of 2007, specifically: (1) reducing the income eligibility from 250% to 200% of the FPL, (2) requiring women to submit annual income documentation, and (3) excluding women with other insurance coverage.
- Throughout the six-year period, Medicaid claims data indicate only about one-quarter of program enrollees actually accessed services in any one year.<sup>18</sup>

**Table 3-1: Maryland Family Planning Program Enrollment and Participation Rates, 2004-2009**

	2004	2005	2006	2007	2008*	2009*
Number of Enrollees on December 31	56,058	53,171	46,342	36,922	27,969	16,245
Total Enrolled for Any Period of Time	70,665	72,625	69,849	62,469	52,094	38,173
Percent of Total Enrollees with at Least One Service	25.6%	24.9%	24.7%	26.0%	27.7%	25.8%

\*New program eligibility rules became effective in 2008, including a lower income limit of 200% FPL rather than 250% FPL and redetermination process that requires women re-enroll annually.

Source: Maryland DHMH. (2010). *Maryland Health Choice Waiver Section 1115 Renewal Application*, p. 55

<sup>14</sup> U.S. DHHS Centers for Medicare and Medicaid Services. (n.d.) *Details for Maryland Health Choice 1115*

<sup>15</sup> Ibid.

<sup>16</sup> Maryland's FFP is usually 50%, but the state is receiving an enhanced rate of about 62% for the first half of FY11. (Maryland Department of Legislative Services. (General Assembly 2010 Session). *HB 1358 Fiscal and Policy Note*)

<sup>17</sup> Tricia Roddy, DHMH Office of Planning, Personal Communication

<sup>18</sup> Maryland DHMH. (2010). *Maryland Health Choice Waiver Section 1115 Renewal Application*, p. 55

**Primary Adult Care Program.** Maryland's Medicaid waiver expands limited medical coverage to single adults (19 or older) up to 116% of the FPL who would not otherwise qualify for Medicaid coverage. To be eligible, a participant must be a U.S. citizen.

The program, which was first implemented in July 2006, provides a variety of primary care services. Except for surgical procedures (e.g., permanent sterilization), it offers the same array of family planning services provided by the Medicaid Waiver Family Planning Program.<sup>19</sup>

Disaggregated data for family planning services usage and costs do not exist. For the program as a whole, in 2009, the program had a total of 48,299 enrollees throughout the year. Roughly 28,738 (59.5%) of enrollees were women, and about 19,000 were ages 19-40.<sup>20</sup> Federal and State program expenditures totaled \$72.4 million in FY09. About 1% of State expenditures were matched at the 90% federal matching rate for family planning services; all other services received the 50% rate.<sup>21</sup>

## **B. Montgomery County Medical Programs**

Montgomery County taxpayer dollars support publicly-funded family planning services accessed by teens and low-income women in Montgomery County in three ways. First, County dollars supplement the State's appropriation of federal and state dollars for three Title X family planning clinics. In addition, some Montgomery Cares clinics provide reproductive health care and family planning services. Finally, although not a family planning program per se, the Maternity Partnership Program provides prenatal and labor and delivery services for low-income uninsured women and is a referral point for family planning services.

**Family Planning Clinics.** Montgomery County has three publicly-funded family planning clinics: Planned Parenthood of Metropolitan Washington, DC; Mary's Center for Maternal and Child Care; and TAYA (Teen and Young Adult Connection) that serve as Title X providers in the County. Planned Parenthood and TAYA each have two locations in the county.

The County supplements a State Reproductive Health Grant for Title X family planning services, and contracts with these clinics to provide reproductive health care and family planning services. Under the contract, the County reimburses contractors at a rate of \$110 per patient for one visit and related follow-up per year for patients with incomes up to 150% of the FPL. Visits for women with incomes between 151% to 250% of the FPL are not subsidized through the contract; however, they are eligible for care at a reduced fee.

FY10 funding for the three contracts totaled \$545,800, including the State Reproductive Health Grant (i.e., Title X) of \$362,800 and \$183,000 in County funds. The contracts are level funded in FY11 at \$545,800, with \$371,670 in State funds and \$174,130 in County funds.<sup>22</sup>

**Montgomery Cares.** Montgomery County's Montgomery Cares program provides primary care services for low-income adults who are County residents. The program does not provide reproductive health care specifically; however, nine clinics provide pelvic exams, Pap tests, and breast exams, and six of the nine clinics provide family planning services including contraceptives. The Montgomery Cares program funds the clinics at a rate of \$62 per patient visit. From July 2009 through May 2010, the Montgomery Cares program spent approximately \$16,000 on contraceptives. Montgomery Cares data do not monitor how many women receive reproductive health services; however, in FY09, 65% (13,700) of patients served were women.<sup>23</sup>

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<sup>19</sup> Maryland DHMH. (n.d.) *Adult Primary Care Program*; Tricia Roddy, DHMH Office of Planning, Personal Communication

<sup>20</sup> Maryland DHMH. (2010). *Maryland Health Choice Waiver Section 1115 Renewal Application*, p. 67

<sup>21</sup> Tricia Roddy, DHMH Office of Planning, Personal Communication

<sup>22</sup> Doreen Kelley, Montgomery County DHHS, personal communication

<sup>23</sup> Doreen Kelley, Montgomery County DHHS, personal communication

**Maternity Partnership and Project Deliver.** Maternity Partnership and Project Deliver are County programs that target low-income and uninsured pregnant women with incomes at or below 185% of the FPL who are County residents. Income eligibility for these programs overlaps with State Medicaid coverage for pregnant women with incomes up to 250% of the FPL. However, the Maternity Partnership and Project Deliver only serve women who are not covered by the State; for example, immigrants who do not meet Medicaid eligibility criteria.

The Maternity Partnership program provides routine prenatal care visits and lab services, including Pap tests and STI and HIV testing, and a postpartum check-up. At the postpartum check-up, women are referred to one of the three clinics the County contracts with for reproductive health services. Three local hospitals – Holy Cross, Washington Adventist, and Shady Grove Adventist – participate in the Maternity Partnership program.

In FY09, the Maternity Partnership program served 2,375 women; however, voluntary enrollment has been declining, leading to a corresponding decrease in expenditures and budget. In FY10, the program served 1,999 women and the County's total contractual expenditures were \$1.6 million. For FY11, the program is budgeted at \$1.7 million to serve 2,136 women. Women pay a co-pay of \$450 for their prenatal care.

Project Deliver, a complementary program for Maternity Partnership patients provides labor and delivery services. Project Deliver is a partnership between the County and doctors who have agreed to deliver babies for the program at a fixed rate. The doctors are hired as temporary County employees, and the County provides the doctors' malpractice insurance for Maternity Partnership deliveries. Medicaid reimburses the County for labor and delivery expenses under the Medicaid emergency services provision.<sup>24</sup>

### **C. Research Results for Maryland Family Planning Programs**

As described in Chapter 1, 49% of pregnancies nationwide are unintended. Unintended pregnancy rates are higher among teens and low-income women, and access to publicly-funded family planning services results in more effective contraceptive methods and reduced rates of unintended pregnancies for these groups.

This section reports data on unintended pregnancy in Maryland; the highlights show:

- 42% of births in Maryland from 2001-2005 were unintended;
- Maryland has higher unintended birthrates among teens (79%) and Medicaid (i.e., low-income) clients (64%);
- Data about estimates of averted pregnancies and births vary widely, from a low estimate by CMS of 38 averted births attributable to Maryland's Medicaid Waiver Family Planning Program in 2009 to a high estimate by Guttmacher of 20,100 averted pregnancies attributable to all publicly-funded family planning programs in 2008;
- Guttmacher estimates the 20,100 averted pregnancies in 2008 saved state taxpayers \$88 million in Medicaid costs.

**PRAMS Data about Rates and Characteristics of Unintended Pregnancies in Maryland.** Maryland participates in PRAMS (the Centers for Disease Control and Prevention Pregnancy Risk Assessment Monitoring System), a survey of women who have recently had a live birth that looks at maternal and child health indicators. This dataset provides more detail about unintended pregnancies.

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<sup>24</sup> Dianne Fisher, Montgomery County DHHS, personal communication

According to PRAMS data, young women and women with Medicaid funded births were more likely to report their pregnancy as unintended (either mistimed or unwanted). They were less likely to have engaged in certain prenatal care behaviors and more likely to face risk factors. Specifically, the survey indicates that in Maryland from 2001-2005:

- 42% of all live births were unintended;
- 64% of all Medicaid-funded births were unintended;
- 79% of all births to women under 20 years old were unintended;
- Women with mistimed or unwanted pregnancies were less likely to take a multivitamin and get prenatal care in the first trimester than women with intended pregnancies; and
- Women with mistimed or unwanted pregnancies were more likely to smoke during and after pregnancy and were more likely to experience postpartum depression. They were also more likely to experience physical abuse.

PRAMS data indicate that among women with unintended pregnancies, 43% were using a form of birth control when they conceived and 57% were not.<sup>25</sup> This suggests improved counseling on pregnancy risk, birth control options, and contraceptive method use may reduce the number of unintended pregnancies.

**CMS Evaluation of Maryland Medicaid Waiver Family Planning Program.** A DHMH memorandum states that a CMS (Centers for Medicare and Medicaid Services) study calculated that the Maryland Family Planning Waiver Program averted only 38 births in 2009. While it is difficult to interpret the program's results without more information about the research methodology;<sup>26</sup> this low number may be related to the program's low utilization rate (only about 26% of enrollees received services in 2009).

**Cost Savings Attributable to Publicly-Funded Family Planning Clinics.** The Guttmacher Institute estimates that, in 2008, Maryland family planning centers helped women avert 20,100 unintended pregnancies, including 8,900 unintended births and 8,400 abortions. Researchers estimate that the State saved over \$88 million that would have been spent on Medicaid births.<sup>27,28</sup>

**Significant Gap between Need and Number of Women Served.** In 2006, about 136,000 women in Maryland, including about 13,000 in Montgomery County, accessed family planning services through a publicly-funded clinic. At best, this means that publicly-funded clinics met 52% of the need in Maryland and 38% of need in Montgomery County. However, since any woman can access care through a Title X clinic regardless of income, the actual need met might be slightly lower. No data exist about how many additional women in need of publicly-funded services accessed private providers through Medicaid.

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<sup>25</sup> Maryland DHMH. (2007). *Focus on Unintended Pregnancy Among Maryland Women Giving Birth, 2001-2005*

<sup>26</sup> Maryland DHMH. (January 4, 2010). Memo: *HB 1279*

<sup>27</sup> Frost, et. al., (2010) *Contraceptive Needs and Services: 2008 Update*

<sup>28</sup> Guttmacher assumed \$166/year/client for family planning services and \$14,006 per Medicaid birth. These amounts are less than the estimates made by Maryland's DHMH and Legislative Services for the Fiscal Notes on the family planning bills (see Chapter 4).

**Table 3-2: Family Planning and Related Services in Maryland and Montgomery County**

Program	Eligibility	Funding Source(s)	Services and Provider Network
<b>Programs with Family Planning Services</b>			
Title X	<ul style="list-style-type: none"> <li>• Low-income (250% FPL or less)</li> </ul>	<ul style="list-style-type: none"> <li>• Federal, State, and County funds</li> <li>• Third party insurance, including Medicaid</li> <li>• Sliding scale patient co-pay</li> </ul>	<ul style="list-style-type: none"> <li>• Full range of family planning and related services</li> <li>• Three clinics under contract with County to provide reproductive health services that meet Title X standards</li> </ul>
Medicaid - Full Coverage	<ul style="list-style-type: none"> <li>• Meet U.S. citizenship/residency requirements; <u>and</u></li> <li>• Adults with dependent children and incomes up to 116% FPL, or</li> <li>• Aged, blind, disabled, medically needy, or</li> <li>• Others with special needs,</li> <li>• Children under age 19 with family incomes up to 300% FPL, or</li> <li>• Young adults age 19 – 21 with incomes up to 116% FPL</li> </ul>	<ul style="list-style-type: none"> <li>• Federal and State funds</li> </ul>	<ul style="list-style-type: none"> <li>• Full range of family planning and related services</li> <li>• All other Medicaid</li> <li>• Medicaid providers (clinics and private physicians)</li> </ul>
Medicaid Waiver - Family Planning Services	<ul style="list-style-type: none"> <li>• Women up to 200% FPL losing full Medicaid coverage after giving birth</li> </ul>	<ul style="list-style-type: none"> <li>• Federal and State funds</li> </ul>	<ul style="list-style-type: none"> <li>• Full range of family planning and related services only</li> <li>• Medicaid providers (clinics and private physicians)</li> </ul>
Medicaid Waiver - Primary Adult Care	<ul style="list-style-type: none"> <li>• Adults without dependent children and incomes up to 116% FPL <u>and</u></li> <li>• U.S. citizen</li> </ul>	<ul style="list-style-type: none"> <li>• Federal and State funds</li> </ul>	<ul style="list-style-type: none"> <li>• Primary care services</li> <li>• Family planning and related services (no surgical services such as sterilization)</li> <li>• Medicaid providers (clinics and private physicians)</li> </ul>
Montgomery Cares	<ul style="list-style-type: none"> <li>• Low-income, and</li> <li>• County resident, and</li> <li>• 18 or older</li> </ul>	<ul style="list-style-type: none"> <li>• County General Fund</li> </ul>	<ul style="list-style-type: none"> <li>• Primary care services and reproductive health/family planning where available</li> <li>• 9 clinics provide reproductive health services</li> <li>• 6 clinics specifically provide family planning services, including contraceptives</li> </ul>

**Table 3-2 con't.: Family Planning and Related Services in Maryland and Montgomery County**

Program	Eligibility	Funding Source(s)	Services and Provider Network
<b>Programs with Pregnancy Care</b>			
Medicaid for Pregnant Women	<ul style="list-style-type: none"> <li>Income up to 250% FPL, <u>and</u></li> <li>Meet U.S. citizenship/residency requirements</li> </ul>	<ul style="list-style-type: none"> <li>Federal and State funds</li> </ul>	<ul style="list-style-type: none"> <li>Full medical coverage, including prenatal, delivery, and postpartum care</li> <li>Automatically enrolled in Medicaid Waiver Family Planning Program if qualified postpartum</li> <li>Medicaid providers (clinics and private physicians)</li> </ul>
Maternity Partnership and Project Deliver	<ul style="list-style-type: none"> <li>Income up to 185% FPL</li> </ul>	<ul style="list-style-type: none"> <li>County General Fund (Maternity Partnership)</li> <li>Medicaid (Project Deliver)</li> <li>\$450 co-pay (Maternity Partnership)</li> </ul>	<ul style="list-style-type: none"> <li>Prenatal care, STD/HIV testing, delivery, postpartum check-up</li> <li>Referral for family planning services</li> <li>Three local hospitals and participating physicians</li> </ul>

## **CHAPTER 4. Legislation Affecting Publicly-Funded Family Planning Services**

Ultimately, access to publicly-funded family planning services is governed by federal and state law and regulation. In addition, program implementation practices impact access to services and program results. This chapter provides an overview of recent legislative efforts affecting publicly-funded family planning services and identifies additional changes to Maryland's program that could improve access.

**Section A** describes direct effects of the recently passed 2010 federal health care reform legislation;

**Section B** summarizes proposed legislation in the Maryland General Assembly that would have created an income-based threshold for Medicaid family planning services; and

**Section C** identifies several actions, including an income-based family planning program, that could improve access to family planning services.

### **A. 2010 Federal Health Care Reform Legislation**

Under the Patient Protection and Affordable Care Act (PPACA) of 2010, states no longer need to apply for a waiver to expand the family planning service coverage offered under Medicaid. Instead, under the new federal legislation, states may amend their State Medicaid plan to create a new family planning services coverage group. The legislation stipulates that:

- Income eligibility may be up to, but not higher than, eligibility limits for pregnant women;
- States may base income eligibility on only the applicant's income (e.g., only the income of a teenage applicant and not that of her parents);
- States may use the same methodology as they use for determining eligibility for pregnant women, including counting the applicant as a household of two;
- States will receive a 90% matching rate for family planning services (e.g., counseling, contraceptives, diagnostic tests) during a family planning visit and the regular matching rate for family planning-related services (e.g., treatment for STDs diagnosed during a family planning visit); and
- States may provide services and receive reimbursement under "presumptive eligibility" which allows participants to receive services for a limited time under a preliminary application until a full application is approved.<sup>1</sup>

In addition, the PPACA mandates that beginning in 2014 states offer at least minimum Medicaid coverage – including family planning services – to all adults with incomes up to 133% of the FPL. When this mandate takes effect,

- The Federal Government will reimburse states 100% of the cost of new services;
- The federal matching rate will gradually be reduced to 90% by 2020; and
- States that implement care for this population before 2014 will still be eligible for a higher matching rate when the mandate takes effect, but the rate may be phased differently.<sup>2</sup>

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<sup>1</sup> U.S. DHHS Centers for Medicare and Medicaid Services. (July 2, 2010.) *Family Planning Services Option and New Benefit Rules for Benchmark Plans*

<sup>2</sup> Kaiser Family Foundation. (April 2010). *Summary of New Health Reform Law*



Currently, Maryland's Medicaid waiver provides:

- Up to five years of family planning services for women with incomes up to 200% of the FPL if they lose coverage following a Medicaid-funded birth; and
- Primary care and family planning services to all single adults up to 116% of the FPL.

In sum, as enacted this year, federal health care reform:

- Allows Maryland to extend family planning services to all women with incomes up to 250% of the FPL (equal to Medicaid eligibility for pregnant women) without needing a waiver; and
- Beginning in 2014, requires Maryland to extend at least primary care and family planning services to all adults with incomes up to 133% of the FPL, versus the current limit of up to 116% of the FPL.

## **B. Recent General Assembly Bills to Establish an Income-based Medicaid Waiver Program**

In 2009 and 2010, legislation that would have extended Medicaid coverage for family planning services to women age 19 or older with incomes at or below 250% of the FPL was introduced in the Maryland General Assembly. In 2009, a bill was introduced only in the House; in 2010, companion legislation was introduced in both the House and the Senate.

In 2010, this legislation – HB 1358 and SB 521,<sup>3</sup> or the Family Planning Works Act – was co-sponsored by Democratic and Republican lawmakers. DHMH supported the concept, but expressed concerns about cost. Both years, this legislation was withdrawn from consideration before a vote primarily due to cost concerns.<sup>4</sup>

Had this legislation passed, the State would have had to amend the State's Medicaid waiver program to receive approval from the federal Centers for Medicare and Medicaid Services to implement the change. (The federal health care reform legislation enacted in January 2010 makes this last step unnecessary for future legislation. The State would need to amend its State Medicaid Plan, but this process is generally much quicker than the waiver process.)

**Estimated Costs.** Despite potential cost savings (see below), legislative staff report that Maryland's current budget shortfalls plus the program's initial cost outlays made lawmakers and DHMH reluctant to pursue expanding Medicaid family planning services at this time.<sup>5</sup>

According to the 2010 fiscal note (Appendix E), the program cost would be \$12.8 million in FY12 and increase to \$15.1 million by FY15. Although many services would qualify for the federal reimbursement rate of 90%, some services would only qualify for Maryland's regular reimbursement rate of 50%. As a result, the fiscal note estimates that Maryland's share of the program cost would be about 20%, or \$2.6 million to \$3.0 million per year.

The note assumes that:

- Approximately 68,500 Maryland women ages 19 to 44 were uninsured and had incomes between 116% and 250% of the FPL;

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<sup>3</sup> See Appendix D for a copy of HB 1358. The Senate Bill was identical.

<sup>4</sup> Jeremy Crandall, Legislative Aide, Office of Delegate Heather R. Mizeur, Personal Correspondence; Maryland DHMH. (January 4, 2010). Memo: *HB 1279*

<sup>5</sup> Jeremy Crandall, Legislative Aide, Office of Delegate Heather R. Mizeur, Personal Correspondence

- About 59% (40,467) of them would enroll in the program;
- The FY12 per enrollee cost would be \$307; and
- \$18,500 in start-up technology costs that would be shared between the State and the Federal Government.<sup>6,7</sup>

In order to address the cost concern, Delegate Heather Mizeur and Senator Catherine Pugh - the lead bill sponsors in 2010 – are pursuing options for private start-up funding for the program.<sup>8</sup>

**Estimated Savings.** The fiscal note does not provide an extensive analysis or a precise estimate of potential Medicaid savings since it is difficult to predict how many unintended pregnancies and births that are currently covered by Medicaid would be averted. According to the fiscal note, Medicaid currently pays for 23,000 births per year. On average, these births cost \$19,000 for prenatal care, labor and delivery, and hospital newborn care.<sup>9</sup>

However, according to the PRAMS survey data, 14,720 (64%) of Medicaid births in Maryland are unintentional pregnancies. At an average cost of \$19,000 each, annual Medicaid expenditures for births from unintended pregnancies total \$279 million. Using an average per birth cost of \$19,000 and an estimate of \$12.8 million to implement an income-based waiver program, the program would have to achieve 670 fewer Medicaid births through averted, unintended pregnancies (3.0% decrease in Medicaid births) to pay the full costs of the program.

Further analysis by the Guttmacher Institute for Delegate Heather Mizeur (using assumptions in the fiscal note) estimates that this expansion would lead to approximately 2,800 averted births per year in Maryland. Given that each Medicaid-funded birth costs the State \$19,000, Guttmacher estimates that Maryland's Medicaid program could realize \$40 million in net cost savings due to the reduction in unintended pregnancies and births.<sup>10</sup>

In addition to Medicaid cost savings, if more women were covered by Medicaid, Title X clinics could have more of their expenses reimbursed by Medicaid. This, in turn, could allow clinics to use their other funds to cover the gap between either the actual cost of care and the Medicaid reimbursement or to provide care for additional clients.

### **C. Potential Strategies to Improve Access to Family Planning Services in Maryland**

An urgent need exists for expanded access to family planning services, particularly for teens and low-income women, in Maryland and nationally. Although Title X is the only federal grant program that specializes in the delivery of family planning services, today Medicaid programs and providers, including state waiver programs, fund more than 80% of all services. Research shows Medicaid waiver programs that establish eligibility for family services for teens and women who meet certain income thresholds effectively expand access.

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<sup>6</sup> Maryland Department of Legislative Services. (General Assembly 2010 Session). *HB 1358 Fiscal and Policy Note*

<sup>7</sup> The fiscal note provides this data for FY11 when the State would have received an enhanced FFP of about 62%. In that case, the State's share of the technology costs would have been \$8,800. In future years, however, these costs are likely to be split evenly, reflecting Maryland's usual federal reimbursement rate of 50%.

<sup>8</sup> Jeremy Crandall, Legislative Aide, Office of Delegate Heather R. Mizeur, Personal Correspondence

<sup>9</sup> Maryland Department of Legislative Services. (General Assembly 2010 Session). *HB 1358 Fiscal and Policy Note*

<sup>10</sup> Jeremy Crandall, Legislative Aide, Office of Delegate Heather R. Mizeur, Personal Correspondence

Maryland's Medicaid programs expand family planning services coverage for very low-income women (up to 116% of the FPL) and for five years postpartum after a Medicaid funded birth for women with incomes up to 200% of the FPL. Although these are important expansions, they only meet a fraction of the need the reproductive health needs of women in Maryland and Montgomery County.

This section offers observations about strategies and practices that could expand access to family planning services in Maryland based on OLO's review of the research literature.

**Implementing an Income-Based Medicaid Family Planning Expansion Program.** Although Maryland was one of the first state's to apply for a waiver to expand access to family planning services, OLO's research income-based expansions are more effective for improving access. Specifically, both the research literature and the recently enacted federal health care legislation recognize the value of an income-based Medicaid family planning expansion program. The General Assembly legislation that would replace the current program with an income-based approach aligns with the research and a federal mandate that will become effective in 2014.

**Establish the Family Planning Income Threshold at 250% of FPL.** The Federal Government's Title X program sets a nationally recognized standard for publicly-funded family planning services. Under Title X, women receive subsidized care if their incomes are up to 250% of the FPL. In addition, the Guttmacher Institute, a well-respected research organization in the women's health field, uses 250% of the FPL as a benchmark to measure need for publicly-funded family planning standards. Finally, Maryland's current income limit for pregnancy-related Medicaid eligibility is 250% of the FPL. If Maryland implements an income-based Medicaid expansion for family planning services, an income threshold at 250% of the FPL would align the program with all three of these standards. At a minimum Maryland should continue to pursue re-instating the 250% income threshold for the current waiver program.

**Consider Eligibility Criteria that Provides Coverage for Teens and Men.** OLO's research found some other states' programs offer coverage to more groups than currently envisioned in Maryland's proposed legislation. Specifically two groups that some states' waiver programs cover that Maryland's proposed legislation excludes are men and women under age 19. (See Appendix C for a list of states covering these groups).

- Maryland's legislation excludes coverage for women under age 19 because they are eligible for full Medicaid coverage under the Maryland Children's Health Program if their household income is up to 200% of the FPL, or, for a premium, up to 300% of the FPL.<sup>11</sup> Extending Family Planning Coverage to this group, however, could provide access to services for young women who would not otherwise seek family planning care under MCHP coverage for confidentiality reasons. If the income limit for the Family Planning Program were 250% of the FPL, it would also provide free care to young women up to a higher income limit than MCHP currently provides.
- Although men are not themselves at risk for pregnancy, they may also benefit from reproductive health counseling, screening, and contraceptive counseling. Extending services to men would be consistent with policies that aim to improve access to reproductive health services and reduce rates of unintended pregnancy.

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<sup>11</sup> Tricia Roddy, DHMH Office of Planning, Personal Communication

**Enrollment.** Maryland's current Medicaid Family Planning waiver program automatically enrolls eligible women for the first year. (To continue enrollment women must re-enroll annually for up to four additional years.) As described in Chapter 2, in addition to automatic enrollment states have taken a variety of steps to ease the enrollment process. Some options to consider that could improve Maryland's enrollment process include:

- Developing a simple, one-page application;
- Allowing women to enroll at community clinics (e.g., Title X funded clinics);
- Establishing "presumptive eligibility" that allows women to receive services on an immediate, short-term basis while full eligibility is determined.

**Outreach.** A strong outreach program that lets women know they are eligible for services, where they can enroll in the program, where they can receive services, and what services are offered will be vital to the program. Whether Maryland chooses to continue automatically enrolling women who lose full Medicaid coverage postpartum or restructures the program to serve women up to a specific income threshold, it will be especially important to reach out to this group.

Currently, women are automatically enrolled in Maryland's Medicaid family planning expansion; however, data indicate that only about one-quarter of them actually receive services. As shown by Alabama's program evaluation, many women in that state who are automatically enrolled for family planning services do not realize they are in the program (see page 20).

The State will also need to reach out to health care providers to educate them about the program, sign them up to participate, and let them know about changes to the program.

**Uses of Potential Medicaid Savings.** The 2010 legislation in the House and Senate anticipates that enactment of an income-based waiver program would increase the number of averted pregnancies and generate significant Medicaid savings. Legislators may wish to consider using a portion of the savings to further improve access to family planning services. For example, funds could be directed to Title X family planning services. Since these Title X clinics serve men and young women and do not have the same citizenship requirements as Medicaid, additional support for these programs could further enhance the availability of care. In fact, current financial strains on Title X services and the ability of Title X to service this wider population prompted DHMH to stress that Title X funds should not be reduced in order to expand Medicaid coverage.<sup>12</sup>

**Establish Standards of Care.** Although Medicaid and Title X may offer the same range of reproductive health services, Title X requirements result in a standardized level of care that Medicaid does not, at this time, guarantee. Although both programs may provide high quality care, women who receive services at a Title X clinic *must* be offered the full range of services during a family planning visit. In contrast, Medicaid providers may or may not routinely provide the full range of services. To improve the uniformity of services, Oregon, which operates an income-based family planning expansion program, requires all providers to agree to meet standards of care that require counseling and education, a comprehensive exam including STI and other testing, and comprehensive contraceptive offerings. Maryland could consider implementing a similar set of requirements for family planning Medicaid providers.

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<sup>12</sup> Maryland DHMH. (January 4, 2010). Memo: *HB 1279*

## **CHAPTER 5. Summary of Findings**

The Council requested this Office of Legislative Oversight report to better understand “Medicaid waiver programs” that expand eligibility for Medicaid family planning services, and how such programs have been implemented in other states. This chapter summarizes OLO’s findings; earlier chapters provide additional context, including detailed descriptions of federal, state, and county programs that provide family planning services.

In sum, OLO’s review of the literature shows that low-income women and young women face much higher risks of unintended pregnancy. To help bridge this gap, 27 states have implemented Medicaid waiver programs. These programs have taken three basic approaches:

- Expansions that provide services based on income;
- Expansions that continue family planning services for women who lose any Medicaid coverage; and
- Expansions that continue family planning services for women who lose coverage after a Medicaid-funded birth.

Several studies show that waiver programs improve access to services by increasing the number of women served, the percent of women in need who access services, and the number of family planning service providers who participate in public programs. One study indicates that income-based waiver programs are more effective than other types of waiver programs at expanding access.

The research demonstrates that waiver programs produce Medicaid cost savings for states and the Federal Government. Although the impact on unintended pregnancy rates is inconclusive, some evaluations indicate that programs reduce birthrates among the target population and program participants.

States have also implemented practices aimed at further improving access to family planning services. These include outreach to the target population and potential new providers, simplified enrollment procedures, special confidentiality rules, and eligibility for teens and men.

Maryland implemented a waiver program in 1995 that extended family planning services to women losing coverage after a Medicaid-funded birth. In 2009 and 2010 the Maryland General Assembly introduced legislation to expand Medicaid family planning services to women based on income. Although the bills were withdrawn – primarily due to concerns about start-up costs – the proposed legislation would have achieved significant long-term savings and improved access to family planning services.

Following federal health care reform legislation passed earlier this year, Maryland would no longer need a waiver to implement the proposed income-based family planning program.

The remainder of this chapter presents OLO’s findings in more detail. This chapter, together with the additional background contained in earlier chapters, provides the basis for a Council discussion on whether to advocate for changes to expand eligibility in Maryland for family planning services based on income.

**Finding #1: Teens and low-income women experience higher rates of unintended pregnancy than other women of reproductive age, exposing them to greater risk of poor health and child development outcomes.**

In 2001, nearly half (49%) of all pregnancies in the United States were unintended. Of these pregnancies, 44% resulted in births, 42% in abortions, and 14% in miscarriages. Unintended pregnancy rates vary by age and income. In 2001, the national unintended pregnancy rate among all women was 51 per 1,000 women. In contrast, comparable rates for young women and by income level were:

- 108 per 1,000 among women ages 18-19 and 104 per 1,000 among women ages 20-24,
- 112 per 1,000 among women with incomes below 100% of the federal poverty level (FPL),
- 81 per 1,000 among women with incomes between 100% and 199% of the FPL, and
- 29 per 1,000 among women with incomes over 200% of the FPL.<sup>1</sup>

In Maryland, unintended pregnancies accounted for: 42% of live births from 2001-2005; 79% of births to women under 20; and 64% of Medicaid-funded births (women with incomes up to 250% of the FPL).<sup>2</sup>

The research indicates that unintended pregnancies expose both women and children to greater risk than intended pregnancies. For example, women with unintended pregnancies are at a higher risk for delaying or not receiving prenatal care, which can increase health risks for mothers and babies.<sup>3</sup> They experience higher rates of postpartum depression,<sup>4</sup> have higher morbidity rates, and are more likely to engage in risky behaviors (e.g., smoking, alcohol consumption, or drug use) during pregnancy.<sup>5</sup> Children born from unintended pregnancies have higher rates of preterm delivery and low birthweight;<sup>6</sup> in addition, they experience lower levels of educational attainment, more mental and physical health problems, and a more stressed mother-child relationship.<sup>7</sup>

**Finding #2: Publicly-funded family planning programs reduce the number of unintended pregnancies among low-income women and teens. Medicaid funds 71% of all publicly-funded family planning services.**

Publicly-funded programs provide access to family planning services for low-income women and teens. The two primary public programs are Medicaid and Title X. Since 1972, federal regulations have required states to provide family planning coverage for individuals who qualify for full Medicaid coverage. Title X is a federally funded grant program established to provide family planning and reproductive health services to low-income women and men. Specifically, these programs offer participants:

- Contraceptive supplies and services, including sterilization;
- Patient counseling and education regarding reproductive health and contraception;
- Breast and pelvic exams;
- Cancer screening;
- Sexually transmitted infection prevention counseling, testing, and referral for treatment; and
- Pregnancy diagnosis and counseling.<sup>8</sup>

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<sup>1</sup> Finer, L.B. & Henshaw, S.K. (2006). *Disparities in Rates of Unintended Pregnancy*

<sup>2</sup> Maryland DHMH. (2007). *Focus on Unintended Pregnancy Among Maryland Women Giving Birth, 2001-2005*

<sup>3</sup> U.S. DHHS Centers for Disease Control. (n.d.) *Unintended Pregnancy Prevention*

<sup>4</sup> The National Campaign to Prevent Teen and Unplanned Pregnancy. (2008). *Consequences of Unplanned Pregnancy*

<sup>5</sup> U.S. DHHS Centers for Disease Control. (n.d.) *Unintended Pregnancy Prevention*

<sup>6</sup> The National Campaign to Prevent Teen and Unplanned Pregnancy. (2008). *Consequences of Unplanned Pregnancy*

<sup>7</sup> Ibid.

<sup>8</sup> U.S. DHHS Centers for Medicare and Medicaid Services. (n.d.) *State Medicaid Manual*; U.S. DHHS Office of Public Health and Science. (n.d.) *Family Planning*

The Guttmacher Institute estimates that public spending for family planning services in 2006 totaled \$1.8 billion. Of this, 71% of expenditures were from Medicaid, 12% from Title X, and 17% from other federal and state programs.<sup>9</sup>

In 2006, these programs allowed nine million clients in the United States to receive publicly-funded family planning services; it is estimated that these services helped women avert about 1.94 million unintended pregnancies. Research shows that:

- Clients of publicly-funded family planning clinics have 78% fewer unintended pregnancies than similar women who do not have access to family planning services;
- Without publicly-funded family planning services unintended pregnancy rates among teens would be 60% higher; and
- Unintended pregnancy rates among women with incomes under 100% of the FPL would double without publicly-funded care.<sup>10</sup>

In 2008, publicly-funded family planning centers in Maryland helped women avert 20,100 unintended pregnancies, including 8,900 unintended births and 8,400 abortions.<sup>11</sup>

**Finding #3: Despite the apparent success of publicly-funded family planning programs, in 2006 only about half of women in need of publicly-funded family planning services received care.**

The Guttmacher Institute defines a woman as *in need of any* family planning services if she is sexually active, able to become pregnant, and is neither pregnant nor trying to become pregnant. The Guttmacher Institute assumes a woman is in need of *publicly-funded* family planning services if she also:

- Is under 20 years old *or*
- Her income is 250% of the FPL or below.<sup>12</sup>

In 2006, Guttmacher estimated that, nationally, about 17.5 million women needed publicly-funded family planning services; at the state and local level, the estimates were 258,560 women in Maryland and 30,560 women in Montgomery County needed publicly-funded family planning services.

Nationally in 2006, only 54% of women who needed publicly-funded family planning services had access to them.<sup>13</sup> Data on how women accessed services at the state and county level are incomplete. In 2006, about 136,000 women in Maryland, including about 13,000 in Montgomery County, accessed family planning services through a publicly-funded clinic.<sup>14</sup> At best, this means that publicly-funded clinics met 52% of the need in Maryland and 38% of need in Montgomery County. However, since any woman can access care through a Title X clinic regardless of income, the need met (under the Guttmacher definition) might be slightly lower. No data exist about how many additional women in need of publicly-funded services accessed private providers through Medicaid.

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<sup>9</sup> Sonfield, et. al., (2008). *Public Funding for Family Planning, Sterilization, and Abortion Services, FY 1980-2006*

<sup>10</sup> Gold, et. al., (2009). *Next Steps for America's Family Planning Program*

<sup>11</sup> Frost, et. al., (2010) *Contraceptive Needs and Services: 2008 Update*

<sup>12</sup> Guttmacher. (2009). *Contraceptive Needs and Services, 2006*

<sup>13</sup> Gold, et. al., (2009). *Next Steps for America's Family Planning Program*

<sup>14</sup> Guttmacher. (2009). *Contraceptive Needs and Services, 2006*

**Finding #4: Some states have implemented Medicaid waiver programs to expand eligibility for family planning services. These programs can be grouped into three broad categories.**

Twenty-seven states, including Maryland, expand access to Medicaid family planning services using waiver programs approved by the federal Centers for Medicare and Medicaid Services. These waiver programs expand family planning Medicaid coverage to people who would not otherwise qualify for Medicaid and allow states to collect federal funds to cover a portion of the state's program costs.

Waiver programs typically provide the full range of family planning services. In addition, some programs cover "family planning related services," such as treatment for conditions diagnosed during a family planning visit (e.g., sexually transmitted infections). State waiver programs can be grouped into three broad categories:

- Expanded income-based eligibility for family planning services. Twenty-one states extend coverage to participants whose incomes exceed the state limit for other Medicaid coverage.
- Continuation of family planning services. Two states allow women who lose Medicaid for any reason, including birth of a child, to continue receiving family planning services for up to two years.
- Extended postpartum-coverage. Four states allow women who lose Medicaid following the birth of a child to continue receiving family planning services for a longer time (two years or more). Maryland has this type of program.<sup>15</sup>

Under the Patient Protection and Affordable Care Act (PPACA) of 2010, states no longer need to apply for a waiver to expand the family planning service coverage offered under Medicaid. Instead, under the new federal legislation, states may amend their State Medicaid Plan to create a new family planning services coverage group.<sup>16</sup>

**Finding #5: Research shows that waiver programs improve access to services and produce Medicaid cost savings. The impact on unintended pregnancy rates is inconclusive. Income-based waivers appear to have the greatest impact on access to services.**

Several studies have considered the impact of state waiver programs on access to family planning services, Medicaid cost savings, and unintended pregnancy rates.

Improved Access. Several studies show that family planning expansion programs improve access to family planning services. Specifically, programs increased the number of women served by publicly-funded family planning programs and increased the number and geographic distribution of family planning providers.<sup>17</sup>

One study indicates that income-based expansions are more effective than other types of expansions at improving access in terms of both the number of women accessing services and the percent of women in need of publicly-funded care that access services.<sup>18</sup>

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<sup>15</sup> Guttmacher. (2010). *State Medicaid Family Planning Eligibility Expansions*

<sup>16</sup> U.S. DHHS Centers for Medicare and Medicaid Services. (July 2, 2010.) *Family Planning Services Option and New Benefit Rules for Benchmark Plans*

<sup>17</sup> Guttmacher (January 26, 2004). *CMS Study of Medicaid Family Planning Waiver Program*

<sup>18</sup> Frost, et. al., (2004). *Availability and Use of Publicly Funded Family Planning Clinics*



**Cost Savings.** Studies demonstrate that waiver programs generate savings for states and the Federal Government because family planning services are less costly than a Medicaid-funded birth and subsequent health care for an infant.<sup>19</sup> One study estimates that states and the Federal Government save, on average, about four dollars for every dollar spent on family planning.<sup>20</sup>

**Impact on Unintended Pregnancy Rate.** OLO's review of three individual state program evaluations found no change either in statewide unintended pregnancy rates or in unintended pregnancy rates among the target population. However, some states have found lower birthrates among certain groups.

- Alabama found a modest decrease in overall birthrate among Medicaid recipients. The state also found a significantly lower birthrate among program enrollees who received services compared to enrollees who did not receive services.
- Data from Wisconsin indicate that teens who received services from the expansion program had a lower birthrate compared to both low-income teens and all teens in the state.<sup>21</sup>

**Finding #6: States have implemented various practices aimed at improving access to their Medicaid waiver programs; few of these practices have been evaluated for their effectiveness.**

Besides outreach to the target population and to potential new providers, states have implemented a variety of practices meant to help make it easier for clients to access services. Specifically, some states:

- Use simple one-page applications plus state and private databases to determine eligibility;
- Automatically enroll eligible women who lose Medicaid coverage or apply for other public programs;
- Allow women to enroll in the program at clinic sites and reimburse clinics for the cost of assistance;
- Grant “presumptive eligibility” that allows women to apply and receive same-day services while full eligibility is determined;
- Guarantee funding for a first visit while an application is pending;
- Help women access necessary documentation – such as birth certificates – at no cost.

States have also implemented special confidentiality practices for teens and women who are at risk of abuse. Such practices include allowing use of alternate contact information and not billing private insurance when a client has confidentiality concerns.

Some states have also extended eligibility to teens and men. In several states that serve teens, teens may apply independently based on their own income and without parental notification.<sup>22</sup>

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<sup>19</sup> Guttmacher (January 26, 2004). *CMS Study of Medicaid Family Planning Waiver Program*; Lindrooth, et. al., (2007). *The Effect of Medicaid Family Planning Expansions on Unplanned Births*

<sup>20</sup> Frost et. al., (2006). *Estimating the Impact of Serving New Clients by Expanding Funding for Title X*

<sup>21</sup> Bronstein, J.M. (2006). *Alabama Plan First Evaluation*; Wisconsin Department of Health and Family Services. (2008). *The Wisconsin Family Planning Waiver: Final Evaluation Report for 2003-2007*; Center for Health Services & Policy Research. (2007). *SC Family Planning Waiver*

<sup>22</sup> Sonfield, et. al., (2008). *State Government Innovation in the Design and Implementation of Medicaid Family Planning Expansions*; Guttmacher. (2010). *State Medicaid Family Planning Eligibility Expansions*

There is limited published evaluation data on the effectiveness of these practices. The literature does, however, caution that states with automatic enrollment procedures need special outreach efforts to make sure women know that they are enrolled, what services they can receive, and how to access them. For example, a study of Alabama's waiver program, which uses automatic enrollment for some women, found that 40% of women did not know they were enrolled in the program.<sup>23</sup>

**Finding #7: Although Maryland was one of the first states to implement a family planning waiver program, recent evaluation data show the program has declining enrollment and low participation rates.**

In 1995, Maryland became one of the first states to receive a waiver from the federal Centers for Medicare and Medicaid Services to extend family planning services to women who were losing Medicaid coverage 60 days after giving birth. The initial waiver has been renewed multiple times, and the current approval period expires June 30, 2011. The State has applied for another extension.

Under the current waiver, Maryland's Family Planning Program provides family planning and related services to postpartum women with incomes up to 200% of the FPL who would otherwise lose full Medicaid coverage after giving birth. After delivery, women who do not qualify or have not applied for full coverage are automatically enrolled in the Family Planning Program for one year. Women can renew their enrollment annually for an additional four years.<sup>24</sup>

A recent evaluation of Maryland's current Medicaid Family Planning Waiver program demonstrates declining enrollment, low participation rates, and limited impact on unintended births.

- Between 2004 and 2009, enrollment declined from about 56,000 to 16,000 participants.
- Enrollment declined steadily between 2004 and 2008. Some of this decline reflects women who enrolled in new Medicaid programs which were implemented in 2006 and 2008 that extended coverage to women with incomes up to 116% of the FPL.
- Three program design factors contributed to 20,000 fewer enrollees at the end of 2009 than at the end of 2007, specifically: (1) reducing the income eligibility from 250% to 200% of the FPL, (2) requiring women to submit annual income documentation, and (3) excluding women with other insurance coverage.
- Throughout the six-year period, Medicaid claims data indicate only about one-quarter of program enrollees actually accessed services in any one year.
- In 2009, the federal Centers for Medicare and Medicaid Services estimates the program only averted 38 births.<sup>25</sup>

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<sup>23</sup> Bronstein, J.M. (2006). *Alabama Plan First Evaluation*

<sup>24</sup> U.S. DHHS Centers for Medicare and Medicaid Services. (n.d.) *Details for Maryland Health Choice 1115*; Alice Middleton, DHMH Office of Planning, Personal Communication; Roddy, DHMH Office of Planning, Personal Communication

<sup>25</sup> Maryland DHMH. (2010). *Maryland Health Choice Waiver Section 1115 Renewal Application*, p. 55; Maryland DHMH. (January 4, 2010). Memo: *HB 1279*

**Finding #8: In 2009 and 2010, State legislation to expand Medicaid family planning services to women based on income was introduced but later withdrawn, primarily due to concerns about start-up costs. If enacted, it is expected that this legislation would generate significant long-term savings and improved access to family planning services.**

Legislation introduced in the Maryland General Assembly in 2009 and 2010 would have improved access to family planning services by expanding Maryland's Medicaid program to provide family planning coverage for women with incomes from 116% to 250% of the FPL. (Women with incomes up to 116% of the FPL already qualify for family planning services through other Medicaid programs.) This would provide parity with Medicaid coverage for pregnant women and align with current eligibility criteria for Title X.

Despite general support for the legislation among committee members and staff at DHMH, it was withdrawn primarily due to anticipated start-up costs of about \$3 million in the first year.<sup>26</sup> Maryland's Department of Legislative Services estimated that the cost of the program in FY12 would have been \$12.8 million dollars. About 80% of this cost would have been reimbursed by the Federal Government.

After the first year, the program would generate significant net savings, however, the fiscal note does not provide an extensive analysis or a precise estimate of potential Medicaid savings since it is difficult to predict how many unintended pregnancies and births that are currently covered by Medicaid would be averted.<sup>27</sup> An estimate provided by the Guttmacher Institute to Delegate Mizeur suggests the proposed program could achieve nearly 2,800 averted births for a net Medicaid savings of \$40 million.<sup>28</sup>

The Department of Legislative Services estimates that in FY12, 68,000 women would have been eligible for the program, and 59% (40,467) of them would have enrolled – significantly increasing the number of women with access to family planning services.<sup>29</sup>

In addition to expanding access under Medicaid, this legislation had the potential to increase capacity for Title X programs. Title X is funded through a federal grant, state appropriations, participant co-pays, and third-party insurance, including Medicaid. If more women were covered by Medicaid, Title X clinics could have more of their expenses reimbursed by Medicaid. This, in turn, could allow clinics to use their other funds to cover the gap between either the actual cost of care and the Medicaid reimbursement or to provide care for additional clients.

**Finding #9: The experiences of other jurisdictions indicate that extending Medicaid family planning eligibility to teens and men could further improve access to family planning services for Maryland and Montgomery County residents.**

Some states' practices allow teens to qualify for Medicaid family planning services based on their own income and/or to waive parental notification requirements. Including these provisions in Maryland legislation could improve access to family planning services for young women by (1) increasing the number of eligible young women and (2) decreasing confidentiality concerns that prevent some young women from accessing care. Specifically:

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<sup>26</sup> Jeremy Crandall, Legislative Aide, Office of Delegate Heather R. Mizeur, Personal Correspondence; Maryland DHMH. (January 4, 2010). Memo: *HB 1279*

<sup>27</sup> Maryland Department of Legislative Services. (General Assembly 2010 Session). *HB 1358 Fiscal and Policy Note*

<sup>28</sup> Jeremy Crandall, Legislative Aide, Office of Delegate Heather R. Mizeur, Personal Correspondence

<sup>29</sup> Maryland Department of Legislative Services. (General Assembly 2010 Session). *HB 1358 Fiscal and Policy Note*

- Women under age 19 qualify for full Medicaid coverage, including family planning, under the Maryland Children's Health Program (MCHP) if their household income is up to 200% of the FPL, and, for a premium, up to 300% of the FPL.<sup>30</sup> Allowing teens to qualify for family planning services based on their own income would greatly increase the number of eligible teens. For example, a teen whose family has no insurance but whose income exceeds 300% of the FPL could qualify for care if her personal income was below 250% of the FPL.
- Studies indicate that many teens will not seek family planning services if a parent must be involved.<sup>31</sup> However, in order to enroll in MCHP, young women must have an adult signature.<sup>32</sup> Allowing young women to apply on their own may encourage some who would not otherwise seek care for confidentiality or other reasons to access family planning services.

Making Medicaid family planning services available to men in Maryland could expand access to care for this population as well. According to the Guttmacher Institute, in 2002 only 30% of men in the United States age 20-44 (of any income level) received a reproductive health service. Currently, eight states' waiver programs extend eligibility for family planning services to men.<sup>33</sup> Services to men frequently include education and counseling, barrier method contraceptives, and sterilization services.

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<sup>30</sup> Tricia Roddy, DHMH Office of Planning, Personal Communication

<sup>31</sup> Sonfield, et. al., (2008). *State Government Innovation in the Design and Implementation of Medicaid Family Planning Expansions*

<sup>32</sup> Alice Middleton, DHMH Office of Planning, Personal Communication

<sup>33</sup> Guttmacher. (2010). *State Medicaid Family Planning Eligibility Expansions*.

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# 2010 POVERTY GUIDELINES\*

ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.

## ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	10,830.00	12,996.00	14,403.90	14,620.50	16,245.00	18,952.50	20,035.50	21,660.00	27,075.00
2	14,570.00	17,484.00	19,378.10	19,669.50	21,855.00	25,497.50	26,954.50	29,140.00	36,425.00
3	18,310.00	21,972.00	24,352.30	24,718.50	27,465.00	32,042.50	33,873.50	36,620.00	45,775.00
4	22,050.00	26,460.00	29,326.50	29,767.50	33,075.00	38,587.50	40,792.50	44,100.00	55,125.00
5	25,790.00	30,948.00	34,300.70	34,816.50	38,685.00	45,132.50	47,711.50	51,580.00	64,475.00
6	29,530.00	35,436.00	39,274.90	39,865.50	44,295.00	51,677.50	54,630.50	59,060.00	73,825.00
7	33,270.00	39,924.00	44,249.10	44,914.50	49,905.00	58,222.50	61,549.50	66,540.00	83,175.00
8	37,010.00	44,412.00	49,223.30	49,963.50	55,515.00	64,767.50	68,468.50	74,020.00	92,525.00

For family units of more than 8 members, add \$3,740 for each additional member.

## MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	902.50	1,083.00	1,200.33	1,218.38	1,353.75	1,579.38	1,669.63	1,805.00	2,256.25
2	1,214.17	1,457.00	1,614.84	1,639.13	1,821.25	2,124.79	2,246.21	2,428.33	3,035.42
3	1,525.83	1,831.00	2,029.36	2,059.88	2,288.75	2,670.21	2,822.79	3,051.67	3,814.58
4	1,837.50	2,205.00	2,443.88	2,480.63	2,756.25	3,215.63	3,399.38	3,675.00	4,593.75
5	2,149.17	2,579.00	2,858.39	2,901.38	3,223.75	3,761.04	3,975.96	4,298.33	5,372.92
6	2,460.83	2,953.00	3,272.91	3,322.13	3,691.25	4,306.46	4,552.54	4,921.67	6,152.08
7	2,772.50	3,327.00	3,687.43	3,742.88	4,158.75	4,851.88	5,129.13	5,545.00	6,931.25
8	3,084.17	3,701.00	4,101.94	4,163.63	4,626.25	5,397.29	5,705.71	6,168.33	7,710.42

Produced by: CMSO/DEHPG/DEEO

\* In accordance with section 1012 of the Department of Defense Appropriations Act of 2010, the poverty guidelines published on January 23, 2009 will remain in effect until updated poverty guidelines are published in March 2010.

## State Medicaid Family Planning Eligibility Expansions

**BACKGROUND:** In recent years, several states have expanded eligibility for Medicaid coverage of family planning services by securing approval (officially known as a “waiver” of federal policy) from the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration). Some states have obtained approval to continue Medicaid coverage of family planning services for women who would otherwise lose Medicaid coverage postpartum. (All states are required to fund pregnancy-related care, including family planning services, for 60 days postpartum to women with incomes up to at least 133% of the federal poverty level—far above states’ regular Medicaid eligibility ceilings.) Other states have granted coverage solely on the basis of income to individuals not previously covered under Medicaid.

### HIGHLIGHTS:

- 27 states have obtained federal approval to extend Medicaid eligibility for family planning services to individuals who would otherwise not be eligible.
  - 4 states have extended eligibility for family planning services to women losing Medicaid postpartum; eligibility generally lasts for two years.
  - 2 states provide family planning benefits for women losing Medicaid for any reason.
  - 21 states provide family planning benefits to individuals based on income; most states set the income ceiling at or near 200% of poverty.
- 8 states provide family planning benefits to men and women.
- 8 states limit their programs to women who are at least 19 years of age; 3 states limit their programs to women who are at least 18 years of age.
- 6 states have adopted procedures allowing clients to apply and receive services at an initial family planning visit while assuring reimbursement to providers.
- 16 of the states with income-based waivers assist providers or clients with application costs.
  - 15 states access necessary documentation at no cost to the applicant.
  - 4 states reimburse providers for the cost of assisting with the application process.



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**CONTINUED**

# STATE MEDICAID FAMILY PLANNING ELIGIBILITY EXPANSIONS

STATE	BASIS FOR ELIGIBILITY			ELIGIBLE CLIENTS INCLUDES		APPLICATION/ REIMBURSEMENT AT FIRST VISIT	ACCESS NECESSARY DOCUMENTS FOR CLIENTS	REIMBURSE PROVIDERS FOR APPLICATION ASSISTANCE	WAIVER EXPIRATION DATE
	Losing Coverage Postpartum	Losing Coverage for Any Reason	Based Solely on Income	Men	Limited to Those 19 and Older				
Alabama			133%		X		X*		9/30/11
Arizona	2 years								9/30/11
Arkansas			200%				X*		1/31/12
California			200%	X		X			6/30/10
Delaware		2 years							6/30/10
Florida		2 years							3/31/10
Illinois		†	200%		X				3/31/12
Iowa	†		200%			X	X*		1/31/11
Louisiana			200%		X		X*	X	7/1/11
Maryland	5 years								6/30/11
Michigan			185%		X		X*		3/1/11
Minnesota			200%	X		X	X		6/30/11
Mississippi			185%						9/30/11
Missouri			185%		X				9/30/10
New Mexico			185%		X‡				3/31/10
New York	†		200%	X			X		9/30/11
North Carolina			185%	X	X		X		9/30/10
Oklahoma			185%	X	X			X	3/31/10
Oregon			185%	X		X <sup>Ω</sup>	X	X	10/31/12
Pennsylvania			185%		X <sup>ψ</sup>	X <sup>Ω</sup>	X		6/1/12
Rhode Island	2 years								9/30/11
South Carolina			185%				X*		12/31/10
Texas			185%		X <sup>ψ</sup>		X*		12/31/11
Virginia	†		133%	X			X		10/30/10
Washington			200%	X			X	X	3/31/10
Wisconsin			200%			X <sup>Ω</sup>	X		12/31/10
Wyoming	Unlimited				X				8/31/13
<b>TOTAL</b>	<b>4</b>	<b>2</b>	<b>21</b>	<b>8</b>	<b>11</b>	<b>6</b>	<b>15</b>	<b>4</b>	

\* Only for clients born in state.

† State also extends Medicaid eligibility for family planning services to these individuals.

‡ Applies to women ages 18–50.

Ω Use state funds to reimburse for some or all initial visits.

ψ Expansion includes women who are at least 18 years of age.

## FOR MORE INFORMATION:

For information on state legislative and policy activity click on Guttmacher's [Monthly State Update](#) and for state level information and data on reproductive health issues, click on Guttmacher's [State Center](#).

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# HOUSE BILL 1358

J1  
HB 1279/09 – HGO

0lr1117  
CF SB 521

By: **Delegates Mizeur, Smigiel, Ross, Barkley, Barnes, Benson, Bronrott, Carr, Frick, Frush, Gaines, Gutierrez, Hixson, Hubbard, Ivey, Kaiser, Kramer, Kullen, Lee, Manno, McHale, McIntosh, Montgomery, Morhaim, Nathan-Pulliam, Niemann, Pena-Melnyk, Ramirez, Reznik, Rosenberg, V. Turner, and Valderrama**

Introduced and read first time: February 18, 2010

Assigned to: Health and Government Operations

## A BILL ENTITLED

1 AN ACT concerning

### 2 **Family Planning Works Act**

3 FOR the purpose of altering the eligibility requirements for family planning services  
4 under the Maryland Medical Assistance Program by requiring the Program to  
5 provide those services to all women whose family income is at or below a certain  
6 percent of the poverty level under certain circumstances; declaring the intent of  
7 the General Assembly; and generally relating to eligibility for family planning  
8 services under the Maryland Medical Assistance Program.

9 BY repealing and reenacting, with amendments,  
10 Article – Health – General  
11 Section 15–103(a)  
12 Annotated Code of Maryland  
13 (2009 Replacement Volume)

14 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF  
15 MARYLAND, That the Laws of Maryland read as follows:

### 16 **Article – Health – General**

17 15–103.

18 (a) (1) The Secretary shall administer the Maryland Medical Assistance  
19 Program.

20 (2) The Program:

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EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.  
[Brackets] indicate matter deleted from existing law.



1 (i) Subject to the limitations of the State budget, shall provide  
2 medical and other health care services for indigent individuals or medically indigent  
3 individuals or both;

4 (ii) Shall provide, subject to the limitations of the State budget,  
5 comprehensive medical and other health care services for all eligible pregnant women  
6 whose family income is at or below 250 percent of the poverty level, as permitted by  
7 the federal law;

8 (iii) Shall provide, subject to the limitations of the State budget,  
9 comprehensive medical and other health care services for all eligible children  
10 currently under the age of 1 whose family income falls below 185 percent of the  
11 poverty level, as permitted by federal law;

12 (iv) Shall provide, subject to the limitations of the State budget,  
13 family planning services to **ALL** women [currently eligible for comprehensive medical  
14 care and other health care under item (ii) of this paragraph for 5 years after the  
15 second month following the month in which the woman delivers her child] **WHOSE**  
16 **FAMILY INCOME IS AT OR BELOW 250 PERCENT OF THE POVERTY LEVEL, AS**  
17 **PERMITTED BY FEDERAL LAW;**

18 (v) Shall provide, subject to the limitations of the State budget,  
19 comprehensive medical and other health care services for all children from the age of 1  
20 year up through and including the age of 5 years whose family income falls below 133  
21 percent of the poverty level, as permitted by the federal law;

22 (vi) Shall provide, subject to the limitations of the State budget,  
23 comprehensive medical care and other health care services for all children who are at  
24 least 6 years of age but are under 19 years of age whose family income falls below 100  
25 percent of the poverty level, as permitted by federal law;

26 (vii) Shall provide, subject to the limitations of the State budget,  
27 comprehensive medical care and other health care services for all legal immigrants  
28 who meet Program eligibility standards and who arrived in the United States before  
29 August 22, 1996, the effective date of the federal Personal Responsibility and Work  
30 Opportunity Reconciliation Act, as permitted by federal law;

31 (viii) Shall provide, subject to the limitations of the State budget  
32 and any other requirements imposed by the State, comprehensive medical care and  
33 other health care services for all legal immigrant children under the age of 18 years  
34 and pregnant women who meet Program eligibility standards and who arrived in the  
35 United States on or after August 22, 1996, the effective date of the federal Personal  
36 Responsibility and Work Opportunity Reconciliation Act;

37 (ix) Beginning on July 1, 2008, shall provide, subject to the  
38 limitations of the State budget, and as permitted by federal law, comprehensive  
39 medical care and other health care services for all parents and caretaker relatives;

1                               1.     Who have a dependent child living in the parents' or  
2     caretaker relatives' home; and

3                               2.     Whose annual household income is at or below 116  
4     percent of the poverty level;

5                               (x)    Beginning on July 1, 2008, shall provide, subject to the  
6     limitations of the State budget, and as permitted by federal law, medical care and  
7     other health care services for adults:

8                               1.     Who do not meet requirements, such as age,  
9     disability, or parent or caretaker relative of a dependent child, for a federal category of  
10    eligibility for Medicaid;

11                              2.     Whose annual household income is at or below 116  
12    percent of the poverty level; and

13                              3.     Who are not enrolled in the federal Medicare  
14    program, as enacted by Title XVIII of the Social Security Act;

15                              (xi)   Shall provide, subject to the limitations of the State budget,  
16    and as permitted by federal law, comprehensive medical care and other health care  
17    services for independent foster care adolescents:

18                              1.     Who are not otherwise eligible for Program benefits;  
19    and

20                              2.     Whose annual household income is at or below 300  
21    percent of the poverty level;

22                              (xii)  May include bedside nursing care for eligible Program  
23    recipients; and

24                              (xiii) Shall provide services in accordance with funding  
25    restrictions included in the annual State budget bill.

26                              (3)    Subject to restrictions in federal law or waivers, the Department  
27    may:

28                              (i)    Impose cost-sharing on Program recipients; and

29                              (ii)   For adults who do not meet requirements for a federal  
30    category of eligibility for Medicaid:

31                              1.     Cap enrollment; and

1                               2.     Limit the benefit package, except that substance  
2 abuse services shall be provided that are at least equivalent to the substance abuse  
3 services provided to adults under paragraph (2)(ix) of this subsection.

4                               (4)    In fiscal year 2011 and each fiscal year thereafter, the Governor  
5 shall include in the State budget funding sufficient to provide the substance abuse  
6 benefits required under paragraph (3)(ii)2 of this subsection.

7               SECTION 2. AND BE IT FURTHER ENACTED, That it is the intent of the  
8 General Assembly that any long-term savings to the Maryland Medical Assistance  
9 Program resulting from the expansion of eligibility for family planning services under  
10 this Act, shall be used to continue the operation of the Upper Shore Community  
11 Mental Health Center in Chestertown.

12               SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect  
13 October 1, 2010.



**Department of Legislative Services**  
Maryland General Assembly  
2010 Session

**FISCAL AND POLICY NOTE**

House Bill 1358 (Delegate Mizeur, *et al.*)  
Health and Government Operations

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**Family Planning Works Act**

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This bill expands eligibility for family planning services in the Medicaid program to all women whose family incomes are at or below 250% of federal poverty guidelines (FPG). The bill also includes intent language that long-term savings to the Medicaid program resulting from expanded services under the bill be used to continue the operation of the Upper Shore Community Mental Health Center (USCMHC).

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**Fiscal Summary**

**State Effect:** Medicaid expenditures increase by \$18,500 in FY 2011 for computer programming expenses. Due to an enhanced federal match (61.6% federal funds, 38.4% general funds) for the first half of FY 2011, \$8,500 will be paid with general funds and \$9,900 will be covered by federal matching funds. Future years reflect the service and personnel costs associated with the expansion of family planning services, with an anticipated 80% federal match. Medicaid expenditures will be offset by savings from a reduction in unintended pregnancies and births. The amount of these savings cannot be reliably estimated but is anticipated to be significant.

(in dollars)	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
FF Revenue	\$9,900	\$10,310,700	\$10,856,600	\$11,462,000	\$12,101,300
GF Expenditure	\$8,500	\$2,577,700	\$2,714,100	\$2,865,500	\$3,025,300
FF Expenditure	\$9,900	\$10,310,700	\$10,856,600	\$11,462,000	\$12,101,300
Net Effect	(\$8,500)	(\$2,577,700)	(\$2,714,100)	(\$2,865,500)	(\$3,025,300)

*Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect*

**Local Effect:** Local health departments may be able to serve additional clients through the Title X Family Planning Program to the extent individuals served under that program are found eligible for Medicaid family planning services.

**Small Business Effect:** Potentially meaningful. Provider reimbursement for family planning services may increase as additional women gain access to family planning services.

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## Analysis

**Current Law/Background:** Eligibility for family planning services under Medicaid (and the Primary Adult Care Program) is limited to women with incomes up to 116% FPG. Women with incomes up to 200% FPG may retain family planning coverage for five years following a birth paid for by Medicaid. This population must complete an active annual redetermination of benefits to retain coverage. Approximately 25,000 women are enrolled in the Medicaid Family Planning Program.

The Department of Health and Mental Hygiene's Family Health Administration provides family planning services through the Title X Family Planning Services Program. This program provides free or sliding scale fee-for-service family planning services to women who are ineligible for Medicaid family planning services through local health departments, Planned Parenthood clinics, and other outpatient units. In fiscal 2010, the program is funded with a total of \$12.32 million (\$8.06 million in general funds and \$4.26 million in federal funds) and serves approximately 75,000 Maryland women at more than 60 clinics.

Typically, family planning services provide pelvic exams; screenings for breast and reproductive cancer, high blood pressure, and diabetes; tests for sexually transmitted diseases; and where appropriate, counseling and prescription for contraception.

Expanding access to family planning services has proven to be cost-effective. A 2003 study funded by the federal Centers for Medicare and Medicaid Services (CMS) found that expansion programs increase access to care, improve availability of services, and save money. The report notes that several states each saved at least \$15.0 million as a result of expanding their family planning coverage.

USCMHC is a psychiatric hospital in Chestertown, Kent County, with a licensed capacity of 64 beds. As part of a plan to move mentally ill and developmentally disabled individuals out of State psychiatric facilities into community placements and other institutional placements, the Board of Public Works (BPW) voted to close USCMHC. Admissions to Upper Shore ceased on January 4, 2010, and the facility plans to close on February 28, 2010. Of the 89 positions at USCMHC as of August 2009, 85 employees need to be "placed," since 4 permanent employees will remain at the center – 2 maintenance employees and 2 security guards, as well as 1 contractual housekeeper. The current tenants of the Upper Shore building, the Whitsitt Center, and the Department

of Juvenile Services program plan to remain at the center and will be assisted with services by the remaining employees of Upper Shore.

As part of the decision to close USCMHC, a series of community service expansions have been proposed – at an annual cost of \$3 million – that are consistent with actions that the department has taken in the past with regard to facility closure. Total facility expenditures in fiscal 2009 – when fully operational – were just under \$9 million.

**State Fiscal Effect:** DHMH advises that, since it will need to negotiate its waiver with CMS prior to enrolling newly eligible women, it does not expect to hire additional eligibility workers or enroll new participants until July 1, 2011. However, DHMH advises that it will begin to reprogram its computer system upon the bill's October 1, 2010 effective date.

Therefore, Medicaid expenditures increase by \$18,448 (\$8,511 in general fund expenditures and \$9,937 in federal fund expenditures, offset by corresponding federal fund revenues) in fiscal 2011, which reflects the cost of reprogramming the Medicaid eligibility computer system to add a new coverage group. Maryland is receiving an enhanced federal Medicaid match (61.6% federal funds, 38.4% general funds) for the first half of fiscal 2011 under the federal American Recovery and Reinvestment Act of 2009, but the match will revert back to Maryland's typical 50% federal medical assistance percentage (FMAP) in the second half of fiscal 2011. However, family planning services typically receive an 80% federal matching rate.

Fiscal 2012 expenditures increase by \$12.88 million, which reflects the cost of hiring eight eligibility workers to process and enroll 40,467 individuals, which more than doubles the currently enrolled population, and family planning service costs. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses. This estimate is based on the following facts and assumptions:

- approximately 68,500 Maryland women ages 19 to 44 are uninsured and have incomes between 116% and 250% FPG;
- 40,467 will be eligible for and will either be automatically enrolled or choose to enroll in Medicaid under the expansion;
- the per enrollee cost for family planning services in fiscal 2012 will be \$307;
- total family planning service costs will be \$12.4 million; and
- an 80% federal matching rate will be provided for personnel and family planning service costs.

DHMH Positions	8
Family Planning Service Costs	\$12,423,369
Salaries and Fringe Benefits for Eligibility Workers	409,569
DHMH Operating Expenses	<u>55,449</u>
<b>Total FY 2012 Expenditures</b>	<b>\$12,888,387</b>
General Funds (20%)	\$2,577,677
Federal Funds (80%)	\$10,310,710

Expansion of family planning services to uninsured women with incomes between 116% and 250% FPG will result in savings to the Medicaid program due to an anticipated reduction in the number of Medicaid births, pregnancy and labor complications, low birth weight babies, infant mortality, and sexually transmitted diseases. The amount of this savings cannot be reliably estimated at this time but is expected to be significant. However, any savings will take time to materialize and will not be collected until long after USCMHC's closure in February 2010.

*For illustrative purposes only*, Medicaid pays for approximately 23,000 births annually. The average cost of a Medicaid birth (including prenatal care, delivery, and hospital newborn care) is \$19,000. For every 100 unplanned pregnancies prevented through expanded family planning services, Medicaid could save \$1.9 million.

Furthermore, to the extent that a portion of the 75,000 women currently served under the Title X Family Planning Program are found eligible for Medicaid family planning services, capacity in that program will increase. For example, if 10%, or 7,500 women currently served under Title X transition to Medicaid under the bill, 7,500 additional women would be able to receive family planning services in the State.

Future year expenditures reflect (1) full salaries with 4.4% annual increases and 3% employee turnover; (2) 1% annual increases in ongoing operating expenses; (3) 1% annual growth in the number of enrollees; and (4) 5.6% medical inflation on the cost of family planning services.

**Additional Comments:** Exhibit 1 displays 2009 FPG by family size.

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**Exhibit 1**  
**2009 Federal Poverty Guidelines**

<u>Family Size</u>	<u>116% FPG</u>	<u>250% FPG</u>
1	\$12,563	\$27,075
2	16,901	36,425
3	21,240	45,775
4	25,578	55,125
5	29,916	64,475

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**Additional Information**

**Prior Introductions:** A similar bill, HB 1279 of 2009, was heard in the House Health and Government Operations Committee and subsequently withdrawn.

**Cross File:** SB 521 (Senator Pugh, *et al.*) - Finance.

**Information Source(s):** Department of Health and Mental Hygiene, Centers for Medicare and Medicaid Services, Department of Legislative Services

**Fiscal Note History:** First Reader - March 12, 2010  
ncs/mwc

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